

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Prince Georges | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b 2 mos. 7 dys. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4283 | | d. STREET ADDRESS 1231 K St. S. E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Jessie | | First Jessie | | Middle Abney | | Last Abney | | 4. DATE OF DEATH Month Dec. Day 6 Year 19 65 | | 5. SEX female | | 6. COLOR OR RACE Negro | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/2/1886 | | 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 11 Hours 3 Min. | | 11. BIRTHPLACE (County & State, or foreign country) Saluda, S. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT decedent | | Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism, site of origin undetermined 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) generalized arteriosclerosis with arteriosclerosis (c) tic heart disease | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) rheumatic heart disease, by history; chronic pyelonephritis; diabetes mellitus; left leg amputation, above knee, due to gangrene. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 9/29 1965 , to 12/6 1965 , that (I) (we) last saw the deceased alive on 12/6 1965 , and that death occurred at 1:30 P. M, from the causes and on the date stated above. | | 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/6/65 | | 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-10-65 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill Men Park Co | | 23d. LOCATION (City, town or county) (State) Wash. D.C. | | 24. FUNERAL DIRECTOR George H. Belter | | 25a. REC'D BY REGISTRAR DEC 13 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie | | c. LENGTH OF STAY IN ID 3 1/2 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES COUNTY HOSPITAL | | | | d. STREET ADDRESS 12611 SAFETY TURN, BOWIE, MD. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Clayton B. Aldrich | | First Middle Last | | 4. DATE OF DEATH 12-24-1965 | | Day Year | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 16, 1893 | | 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST | | 10b. KIND OF BUSINESS OR INDUSTRY DRUGGIST | | 11. BIRTHPLACE (County & State, or foreign country) TAUNTON, MASS. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME CASSIUS M. ALDRICH | | | | 14. MOTHER'S MAIDEN NAME MARY HANNAH BARRY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) YES | | 16. SOCIAL SECURITY NO. 577-05-9217 | | 17. INFORMANT James J. Torrillo (Son-in-law) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary arteriosclerotic heart disease with old myocardial infarction and right bundle branch block DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) emphysema, pulmonary, chronic with frequent acute asthmatic like attacks | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) - | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (we) attended the deceased from Nov 27 , 19 62 , to Dec 24 , 19 65 , that (I) (we) last saw the deceased alive on Dec 22 , 19 65 , and that death occurred at 1:29 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John Cosma, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Dec 24, 1965 | |
| 22c. PHYSICIAN'S NAME (Type) John Cosma, M.D. | | | | 22d. ADDRESS 3010 Stonybrook Drive, Bowie, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-28-1965 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. DC. | | | | 25a. REC'D BY REGISTRAR JAN 3 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>48 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>2709 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>8-18-1892</u> 9. AGE (In years last birthday) <u>73</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Bather</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | 4. DATE OF DEATH <u>Dec. 9 1965</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Clinton, Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William Armstrong</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>577 10 4319</u> 17. INFORMANT <u>Richard B. Farr</u> <u>7720 Walker Mill Rd. Washington D.C.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/9/63</u> , 19 <u>63</u> , to <u>12/9</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/8 1965</u> , and that death occurred at <u>2:35 AM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Frederick E. Musser</u> | | | | 22b. DATE SIGNED <u>12/9/65</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4410 74th Avenue, Bellemead, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/13/65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | | |
| 24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 13 1965</u> DATE | | | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Prince George | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b YEARS | | d. STREET ADDRESS 428 Ethan Allen Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Charles R. Ashford | | 4. DATE OF DEATH Month Day Year 12 22 19 65 | | 5. SEX Male | |
| 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1897 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days 68 | | IF UNDER 24 HRS. Hours Min. 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC'S HELPER | | 10b. KIND OF BUSINESS OR INDUSTRY Bromwell Fireplace | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME JOSEPH FRANKLIN ASHFORD | | 14. MOTHER'S MAIDEN NAME GEORGINA GRIMES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 579-01-1693 | | 17. INFORMANT BURTON BROMWELL, 10704 New Ham, Ave S.E. Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic heart disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12-23-65 | |
| 20f. (City or town) 12-23-65 | | (County) 12-23-65 | | (State) 12-23-65 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12-23-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 28, 1965 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | |
| 22d. LOCATION (City, town, or county) Arlington, Virginia | | 22e. REC'D BY REGISTRAR DEC 29 1965 | | 22f. REGISTRAR'S SIGNATURE Charles Judge | |
| 23. FUNERAL DIRECTOR J. Arthur Watter, 254 Carroll St NW DC | | ADDRESS | | | |

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[Faint, mostly illegible text covering the main body of the document, possibly a ledger or report with multiple columns and rows.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>16770</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>20160</p> </div> </div> | | | | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANHAM MD</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARLOW - HTS</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MAGNOLIA NURSING HOME</u> | | | | | d. STREET ADDRESS <u>2342 - KIRBY DRIVE</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>MAE</u> Last <u>BEALL</u> | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1965</u> | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/3/1890</u> | | 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>CHARLES ALSOP</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>CORNELIA McDONALD</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ELENOR VANCE</u> Address <u>3907 - PA. AVES. E. WASH. D.C.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>334X</u> DUE TO (b) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> (c) <u>Pneumonia</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 wk</u> <u>4 days</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> , to <u>Nov</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12/13/65</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>3408 R. I. Que. Mt. Rainier</u> | | | | | 22d. ADDRESS <u>LEON R. LEVITSKY</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF <u>12/15/65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | | 23d. LOCATION (City, town or county) (State) <u>SCITLAND, MD.</u> | | | |
| 24. FUNERAL DIRECTOR <u>R.A. Mattingly</u> | | | | | ADDRESS <u>131-11th St. S.E.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 17 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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TO HOSPITAL: The law requires that the certificate be executed within 24 hours after death. Page 4, be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16777

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 1707 | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro d. STREET ADDRESS RFD 1707 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James Edwin Bean | | 4. DATE OF DEATH Month December Day 17 Year 1965 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 9, 1907 | |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Mins. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 11. BIRTHPLACE (County & State, or foreign country) Forestville, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Arcenious W. Bean | | 14. MOTHER'S MAIDEN NAME Jane Louise Tolson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT Mrs. Dorothy Fenno Bean- #2 | | Address Same as Item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple metastases Carcinoma of left main bronchus & lung DUE TO (b) 6 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Dec 1965 to 17 Dec 1965 , that (I) (we) last saw the deceased alive on 16 Dec 1965 , and that death occurred at 12 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert B. Sasser, M. D. | | 22b. DATE SIGNED 12/17/65 | |
| 22c. PHYSICIAN'S NAME (Type) Robert B. Sasser, M. D. | | 22d. ADDRESS Upper Marlboro, Maryland: | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/20/65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery | | 23d. LOCATION (City, town or county) (State) Forestville Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md. | | 25a. REC'D BY REGISTRAR DEC 27 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 1820 Trenton Pl., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Herman T. Bell
First Middle Last

4. DATE OF DEATH 12 14 19 65
Month Day Year

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 9 April 1939
9. AGE (In years last birthday) 26 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY North Carolina 11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME Herman T. Bell 14. MOTHER'S MAIDEN NAME Rowena Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Joyce C. Bell 1820 Trenton Place, S.E.
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive subarachnoid hemorrhage
DUE TO
(c) Hypertensive heart disease
INTERVAL BETWEEN ONSET AND DEATH minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

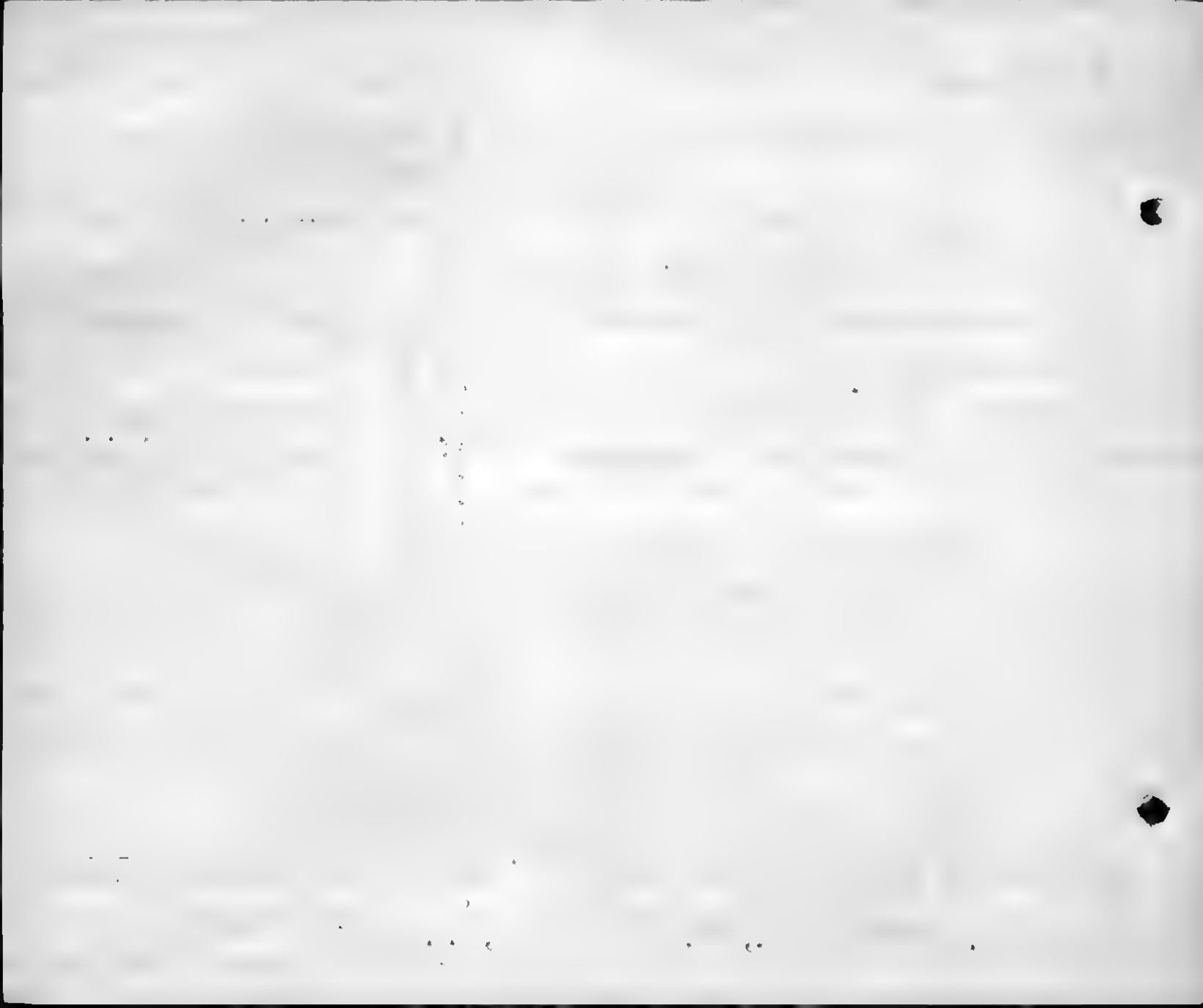
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12-14-65

ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md. Address (Street, city, town, or county)

EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/20/1965 22c. NAME OF CEMETERY OR CREMATORY Arlington 22d. LOCATION (City, town, or county) Arlington, Virginia (State)

23. FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc. 1432 You Street, N.W. 24a. REC'D BY REGISTRAR DEC 17 1965 24b. REGISTRAR'S SIGNATURE Charles Judge



6 1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
SM 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16779

Item #14 Film #G372 1/2/75 PC

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | e. LENGTH OF STAY in 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | d. STREET ADDRESS 6306 46th. Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Raymond Kinglerly Bell | | 4. DATE OF DEATH Month Day Year 12 13 19 65 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 July 1994 | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR (RETIRED) | | 10b. KIND OF BUSINESS OR INDUSTRY TRUCK | | 11. BIRTHPLACE (State or foreign country) DAUPHIN, PENNA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOSEPH BELL | | 14. MOTHER'S MAIDEN NAME HATTIE BELL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 197-10-7048 | | 17. INFORMANT LENA BELL - 6306-46 Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | DATE SIGNED 12-13-65 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/16/65 | | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L | |
| | | | | 22d. LOCATION (City, town, or county) (State) ARLINGTON VA. | |
| 23. FUNERAL DIRECTOR W.W. CHAMBERS Co. | | ADDRESS Riverdale, Md. | | 24. REC'D BY REGISTRAR DEC 15 1965 | |
| | | | | 25. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

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✓ 2024H Ber Unknown
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

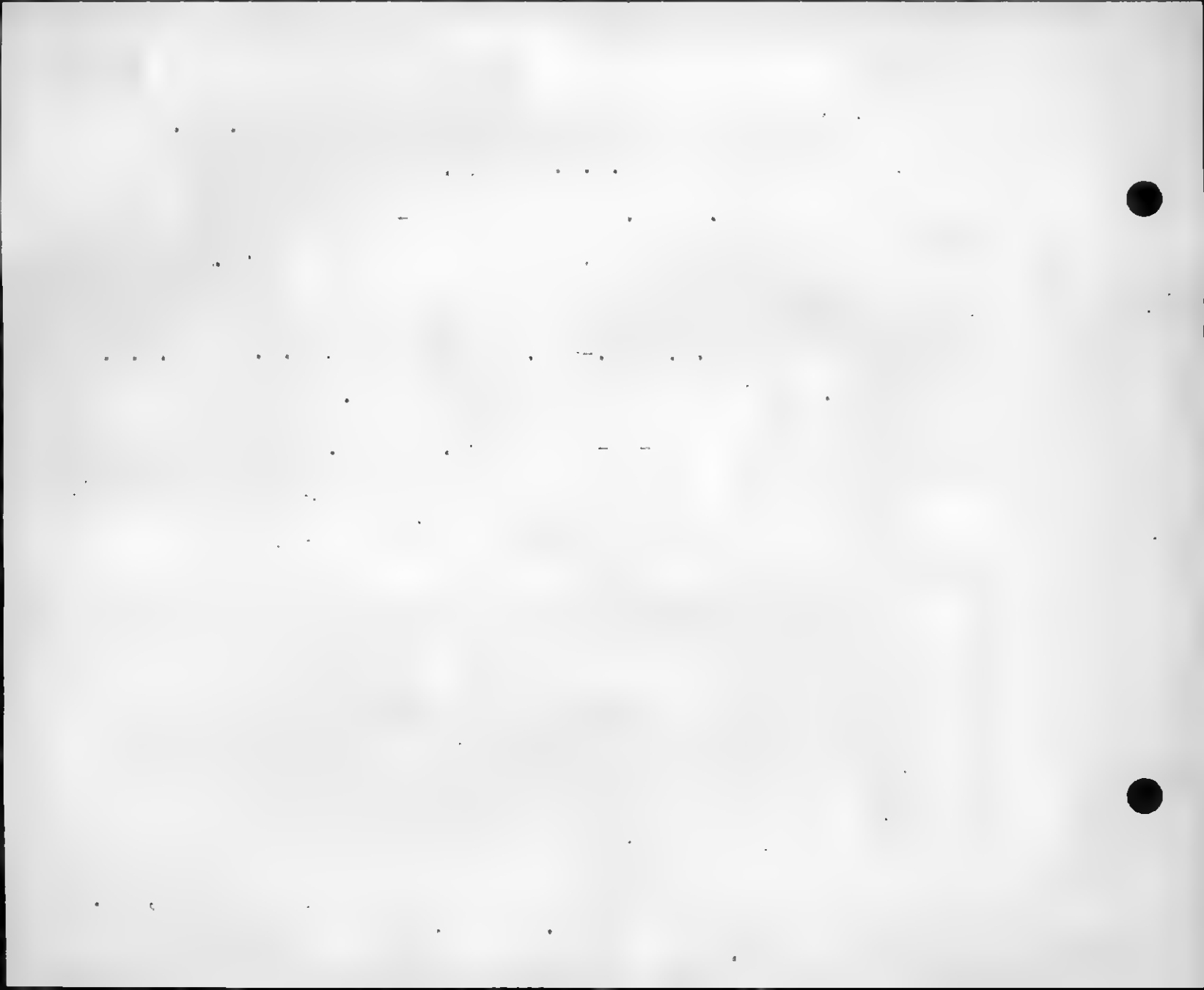
CERTIFICATE OF DEATH

16780

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------------|--|-------------------------------------------------------|--|--|--|------------------------------------------------------------|--|--|--|
| <p>1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp.</p> | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4301 - Kaywood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | | | | | | | | | | | | | | | | |
| <p>3. NAME OF DECEASED (Type or print) Leonard A. Blush</p> | | <p>4. DATE OF DEATH Dec. 5 1965</p> | | <p>5. SEX Male</p> | | <p>6. COLOR OR RACE White</p> | | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH 6/1/1903</p> | | <p>9. AGE (In years last birthday) 62 yrs.</p> | | <p>10. UNDER 1 YEAR Months Days Hours Min.</p> | | <p>11. UNDER 24 HRS. Hours Min.</p> | | | | | | | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist</p> | | | | <p>10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. - Ret.</p> | | | | <p>11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.</p> | | | | <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> | | | | | | | | | | | |
| <p>13. FATHER'S NAME Edwin H. Blush</p> | | | | | | | | <p>14. MOTHER'S MAIDEN NAME Gertrude B. McDonald</p> | | | | | | | | | | | | | | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No</p> | | | | <p>16. SOCIAL SECURITY NO. 579-10-0996</p> | | | | <p>17. INFORMANT Mrs. Mary L. Blush (above address)</p> | | | | <p>Address</p> | | | | | | | | | | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (Wife) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Atherosclerotic Heart Disease OUE TO (c) 2 years</p> | | | | | | | | | | | | | | | | | | | | | | | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | | | | | | | | | | | | | | | | | | | | | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | | | | | | | | | | | | | | | | | | |
| <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> | | | | <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> | | | | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> | | | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | | | <p>20f. (City or town) (County) (State)</p> | | | | | | | |
| <p>21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1964 to Dec 5, 1965, that (I) (we) last saw the deceased alive on Dec 5, 1965, and that death occurred at 8 A.M. from the causes and on the date stated above.</p> | | | | | | | | | | | | | | | | | | | | | | | |
| <p>22a. SIGNATURE Samuel J. N. Sugar M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12-5-65</p> | | | | | | | | | | | | | | | | | | | | | | | |
| <p>22c. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR 22d. ADDRESS 4657 EASTERN AVE WASH DC</p> | | | | | | | | | | | | | | | | | | | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p> | | | | <p>23b. DATE THEREOF 12/8/65</p> | | | | <p>23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery</p> | | | | <p>23d. LOCATION (City, town or county) (State) Colmar Manor, Md.</p> | | | | | | | | | | | |
| <p>24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.</p> | | | | | | | | <p>ADDRESS Mt. Rainier, Maryland</p> | | | | | | | | <p>25a. REC'D BY REGISTRAR DEC 10 1965</p> | | | | <p>25b. REGISTRAR'S SIGNATURE Charles Judge</p> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

16781

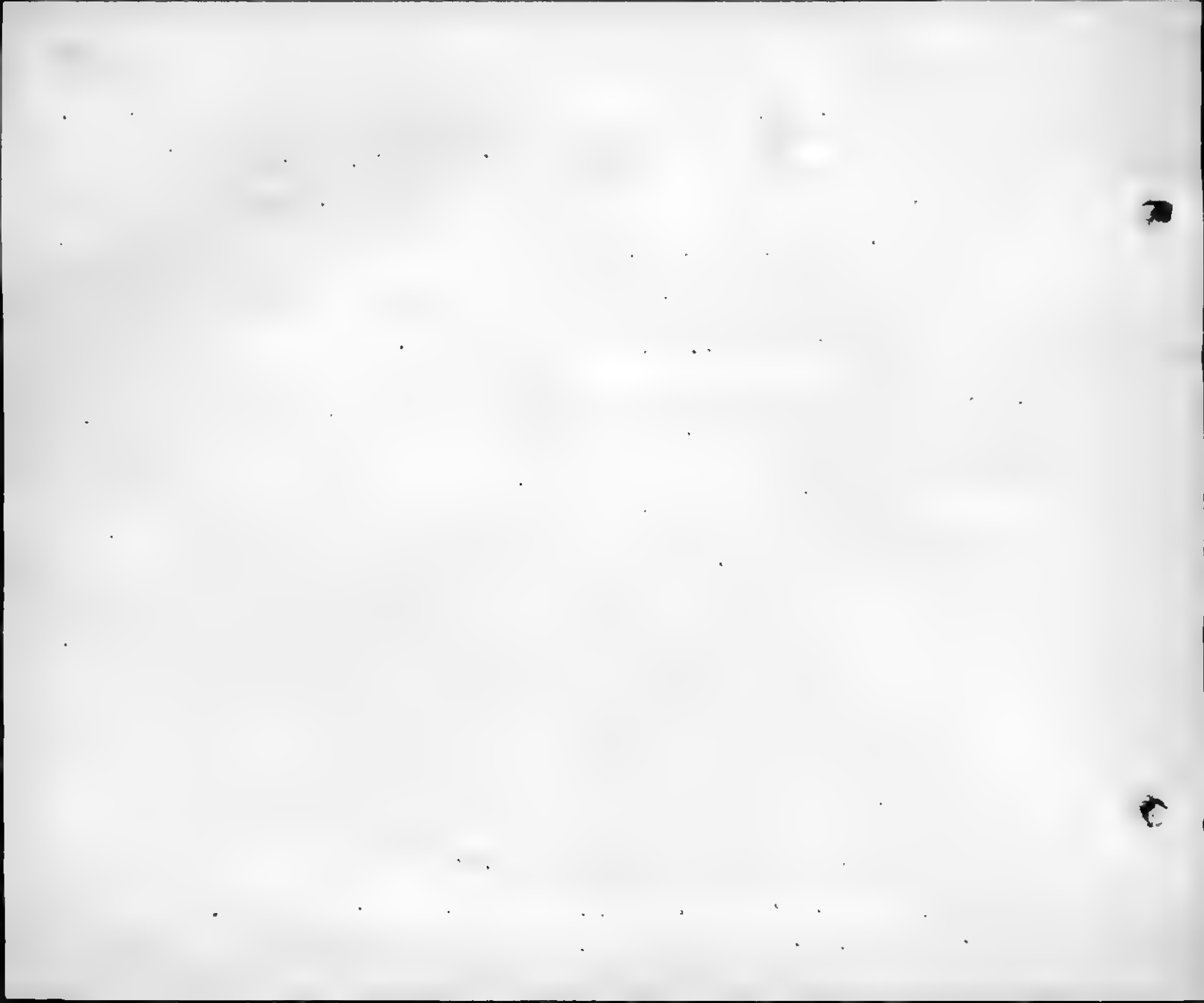
Item #12 Film #5372 1/3/50 pg

Reg. Dist. No.

185

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| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HTS</u> c. LENGTH OF STAY IN 1b <u>1541 S</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5630 23rd PARKWAY</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE-GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HTS</u> d. STREET ADDRESS <u>5630 23rd PARKWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>VINCENZA DEL BROCCO</u> First Middle Last 5 SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB 8, 1891</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS | | 4. DATE OF DEATH <u>12-23</u> Month Day Year <u>1965</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (State or foreign country) <u>ITALY</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH OLIVETTI</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT <u>MRS PHYLLIS ROBERTSON</u> Address <u>5630 23rd Plwy Hillcrest Hts</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable CVA.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> (c) <u>Atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>YEARS</u> <u>YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8-23</u> , 19 <u>65</u> , to <u>9-11</u> , 19 <u>65</u> , that I last saw the deceased alive on <u>9-11</u> , 19 <u>65</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Therese A. Peric</u> M.D. PHYSICIAN'S NAME (Type) <u>MICHAEL A. HUICI 5800 LIVINGSTON RD. WASH. D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>12-27-65</u> 22c. NAME OF CEMETERY OR CREMATORY <u>GREENSBURG CATHOLIC</u> 22d. LOCATION (City, town, or county) (State) <u>GREENSBURG, PA.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>W W CHAMBERS, 517 HAST SE</u> ADDRESS <u>5800 LIVINGSTON RD. WASH. D.C.</u> 24a. REC'D BY REGISTRAR <u>DEC 28 1965</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

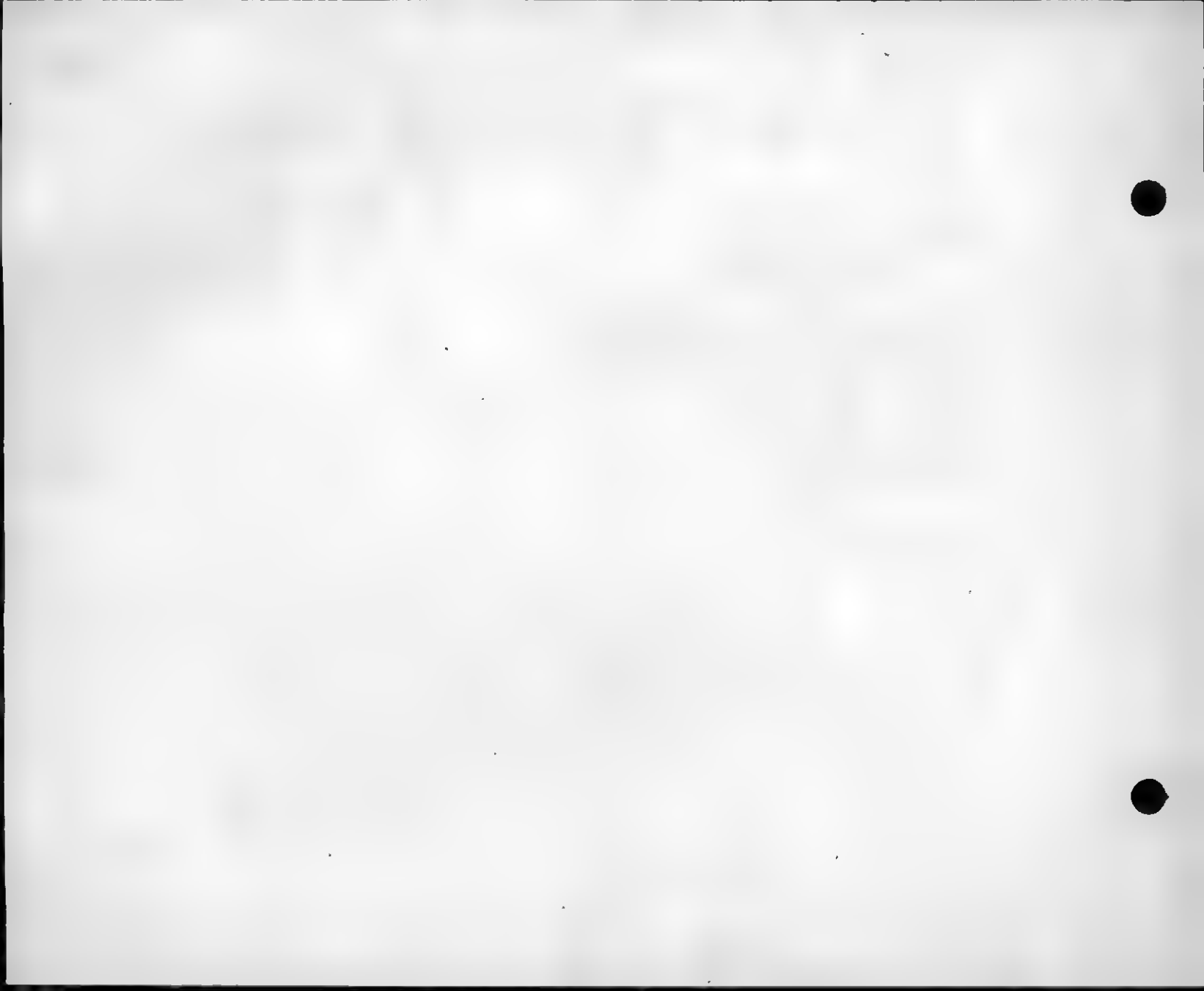
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16782
CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Hill d. STREET ADDRESS 5410 Thompson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Herbert Middle Brown Last Brown | | 4. DATE OF DEATH Month December Day 27 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 29, 1900 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | 11. BIRTHPLACE (County & State, or foreign country) Md |
| 13. FATHER'S NAME Boss Brown | | 14. MOTHER'S MAIDEN NAME Hester Victoria Campbell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | 17. INFORMANT Alice J Campbell Address Same as 2D |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) '419 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the Tongue, Metastatic and Terminal (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1965, to Dec. 27, 1965, that (I) (we) last saw the deceased alive on Dec. 27, 1965, and that death occurred at 11:05 PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE C. Louis Mendel | | 22b. DATE SIGNED Dec. 28, 1965 | |
| 22c. PHYSICIAN'S NAME (Type) C. Louis Mendel, M.D. | | 22d. ADDRESS 4410 74th Ave. Bellemead, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12-31-65 | 23c. NAME OF CEMETERY OR CREMATORY Holy Family Cem | 23d. LOCATION (City, town or county) (State) Woodmore Md |
| 24. FUNERAL DIRECTOR Henry S. Washington & Sons - 4925 Newmarket Rd | | 25a. REC'D BY REGISTRAR DEC 30 1965 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

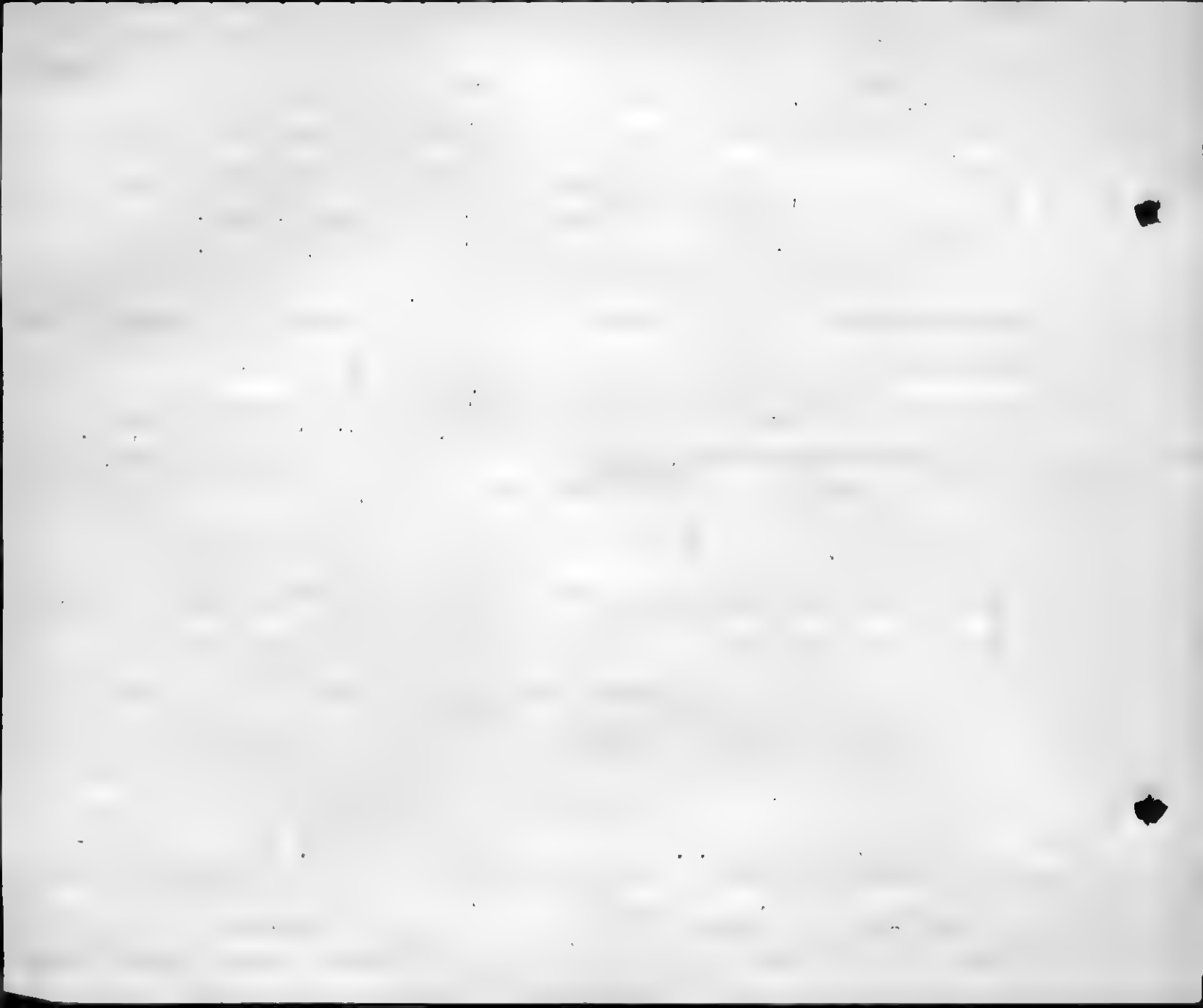
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

16783

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville d. STREET ADDRESS 3417 Tulane Drive Apt. 24 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First: Donald Middle: James Last: Brownnett | | 4. DATE OF DEATH Month: Dec. Day: 21 Year: 1965 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18, 1932 |
| 9. AGE (In years last birthday) 33 yrs. | | 10. IF UNDER 1 YEAR Months: Days: Hours: Min. | 11. IF UNDER 24 HRS. Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY University of Md | |
| 11. BIRTHPLACE (State or foreign country) Hudson New Jersey | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Milton Brownnett | | 14. MOTHER'S MAIDEN NAME Cecelia Boyle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no | | 16. SOCIAL SECURITY NO. 137 26 7982 | |
| 17. INFORMANT Sharon F. Brownnett | | Address W Hyattsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Status asthmaticus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH minutes 20 years |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md. Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 24, 1965 | |
| 22c. NAME OF CEMETERY OR CREMATOR St Gertrude | | 22d. LOCATION (City, town, or county) (State) Rahway New Jersey | |
| 23. FUNERAL DIRECTOR F. Gasch's Sons | | 24a. REC'D BY REGISTRAR DEC 27 1965 | |
| ADDRESS Hyattsville, Md. | | 24b. REGISTRAR'S SIGNATURE J Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

16788

168

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. (PM3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croom</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trump Hill Road</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Francis Bryant</u> | | | | 4. DATE OF DEATH <u>12</u> <u>27</u> <u>19</u> <u>65</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12 Jan. 1918</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John F/ Bryant</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alice Lewis</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Grace A. Bryant Hunt</u> Address <u>----Sister</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Depressed fracture of skull</u> <u>1734</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car which went off road and over turned.</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>11:41 a.m. 12-27- 1965</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Melwood Road, Forestville, Prince George Co.,</u> | | 20f. (City or town) (County) <u>Md.</u> (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-28-65</u> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Dec. 31, 1965</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park Highland Park Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR <u>Henry L. Washington & Sons - 4925 Adams Ave. NE</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 3 1966</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

VR A15ME
SM 1/63

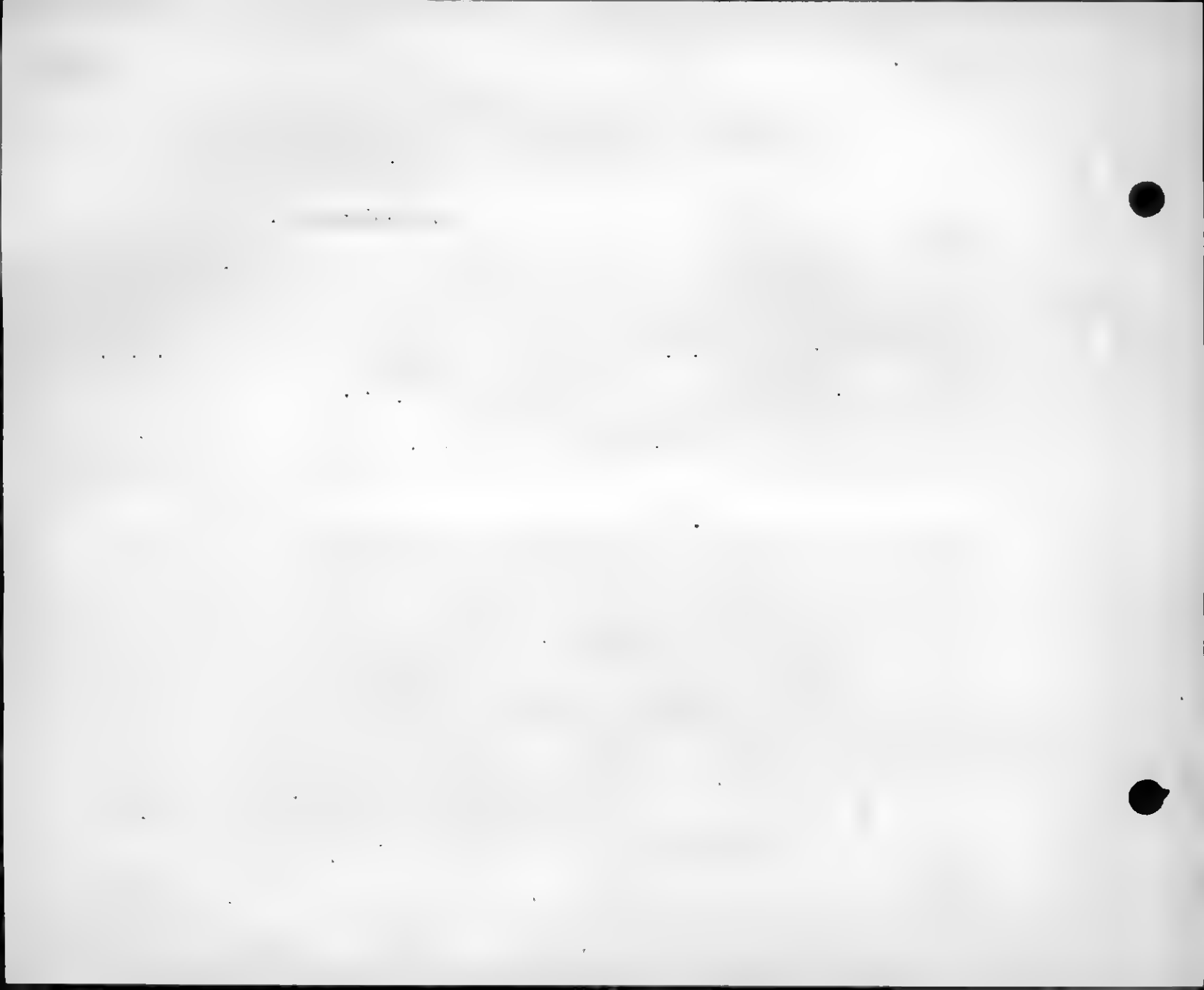


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>11</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u> d. STREET ADDRESS <u>6221 Kenilworth Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>J.</u> Last <u>Bullard</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1965</u> | |
| 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 12, 79</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Accountant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew Bullard</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna H. Jessup</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214 52 6509</u> 17. INFORMANT <u>Marion P. Baillie Same as #2 (daughter)</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Embolic</u> DUE TO (b) <u>Phlebotrombosis of the lower extremities</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 23</u> , 19 <u>65</u> , to <u>Dec. 4</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4</u> , 19 <u>65</u> and that death occurred at <u>9:30</u> M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. Aaron Deitz</u> | | 22b. DATE SIGNED <u>6 Nov. 1965</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Aaron Deitz</u> | | 22d. ADDRESS <u>Hyattsville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE THEREOF <u>12/6/65</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Hawkins Funeral Home</u> | | 23d. LOCATION (City, town or county) (State) <u>Sarasota, Florida</u> | |
| 24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 8 1965</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

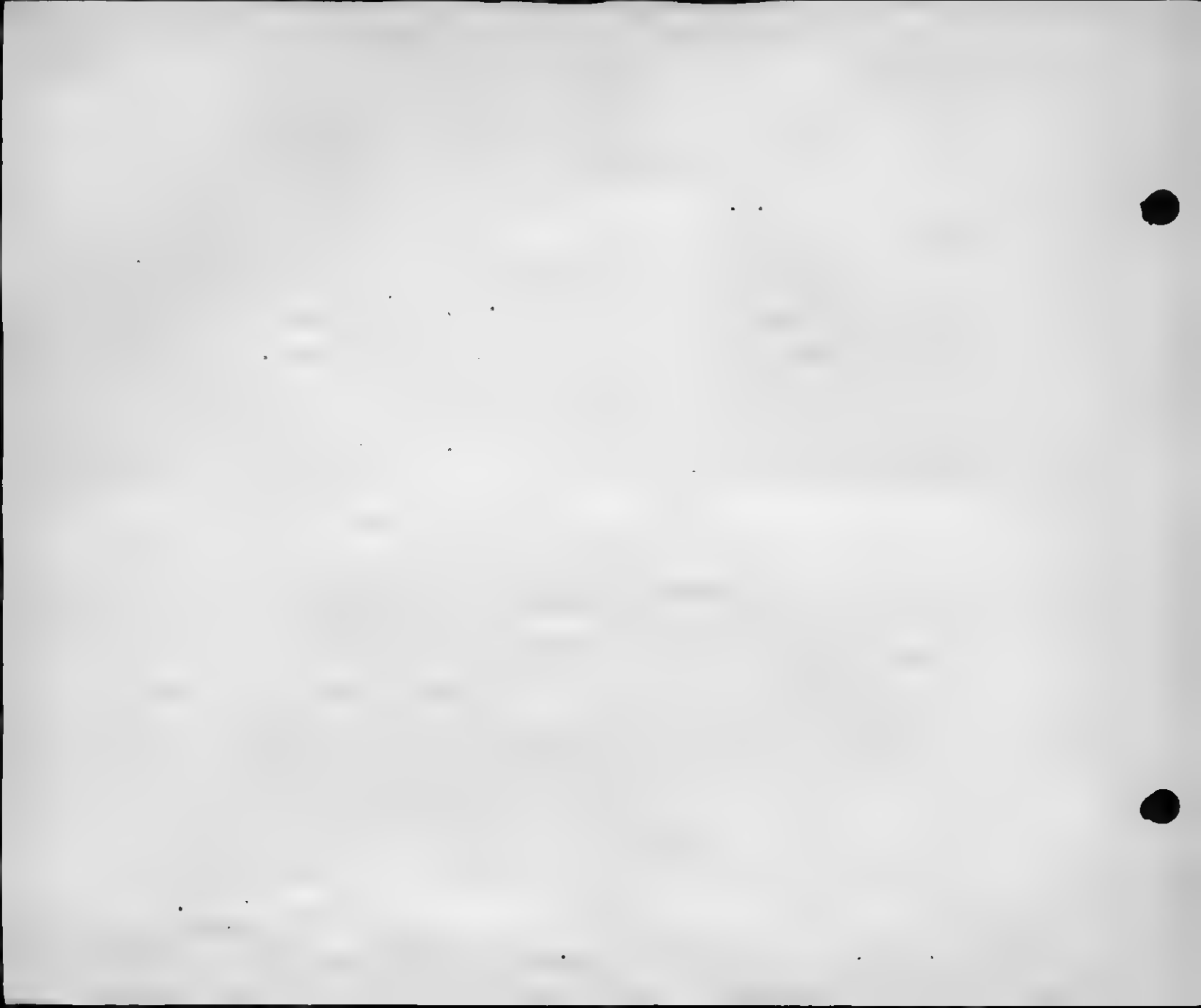
CERTIFICATE OF DEATH

16786

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5308 O Street, S.E.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundle</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM JAMES BURKE</u> | | 4. DATE OF DEATH Month Day Year <u>December 3, 1965</u> | | 5. SEX <u>Male</u> | | | | | | | | | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 15, 1881</u> | | | | | | | | | |
| 9. AGE (In years last birthday) <u>84</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Nicholas, Penna.</u> | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Patrick Burke</u> | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Bridgett Sheehan</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Thos. J. Burke - "ld above"</u> | | | | | | | | | |
| 17. INFORMANT Address <u>Thos. J. Burke - "ld above"</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1949</u> , to <u>Dec 3, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 1, 1965</u> , and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>James C. Cawood</u> | | 22b. PHYSICIAN'S NAME (Type) <u>JAMES C. CAWOOD</u> | | 22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>2520 Pa Ave SE, Washington DC</u> | | | | | | | | | |
| 22e. DATE SIGNED <u>12/3/65</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | | | | | | |
| 23b. DATE THEREOF <u>12/6/65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Jan. T. Ryan, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |
| ADDRESS <u>317 Pa. Ave., SE DC3</u> | | | | | | | | | | | | | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

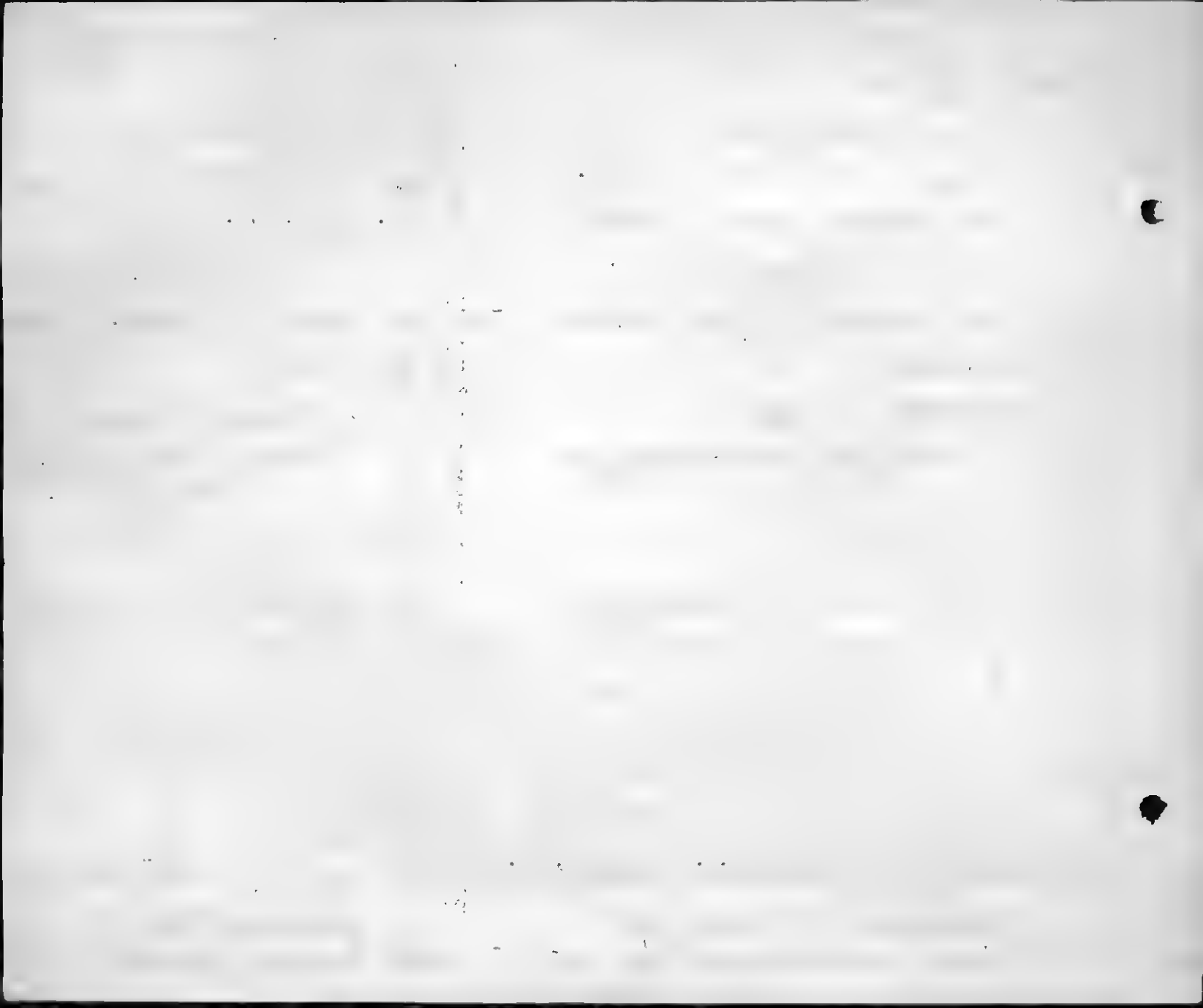
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16787

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| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4117 Minn. Avenue, N.E.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | e. LENGTH OF STAY in lb <u>30 min.</u> | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Daniel Bussie</u> | | | | 4. DATE OF DEATH <u>12 14 19 65</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-17-1882</u> | 9. AGE (In years last birthday) <u>83</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. DATE SIGNED <u>12-15-65</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | | | <u>HARMONY</u> | | <u>MARYLAND</u> | |
| 23. FUNERAL DIRECTOR <u>UNIVERSAL</u> | | | | 24a. REC'D BY REGISTRAR <u>816-H ST. NOV 20 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



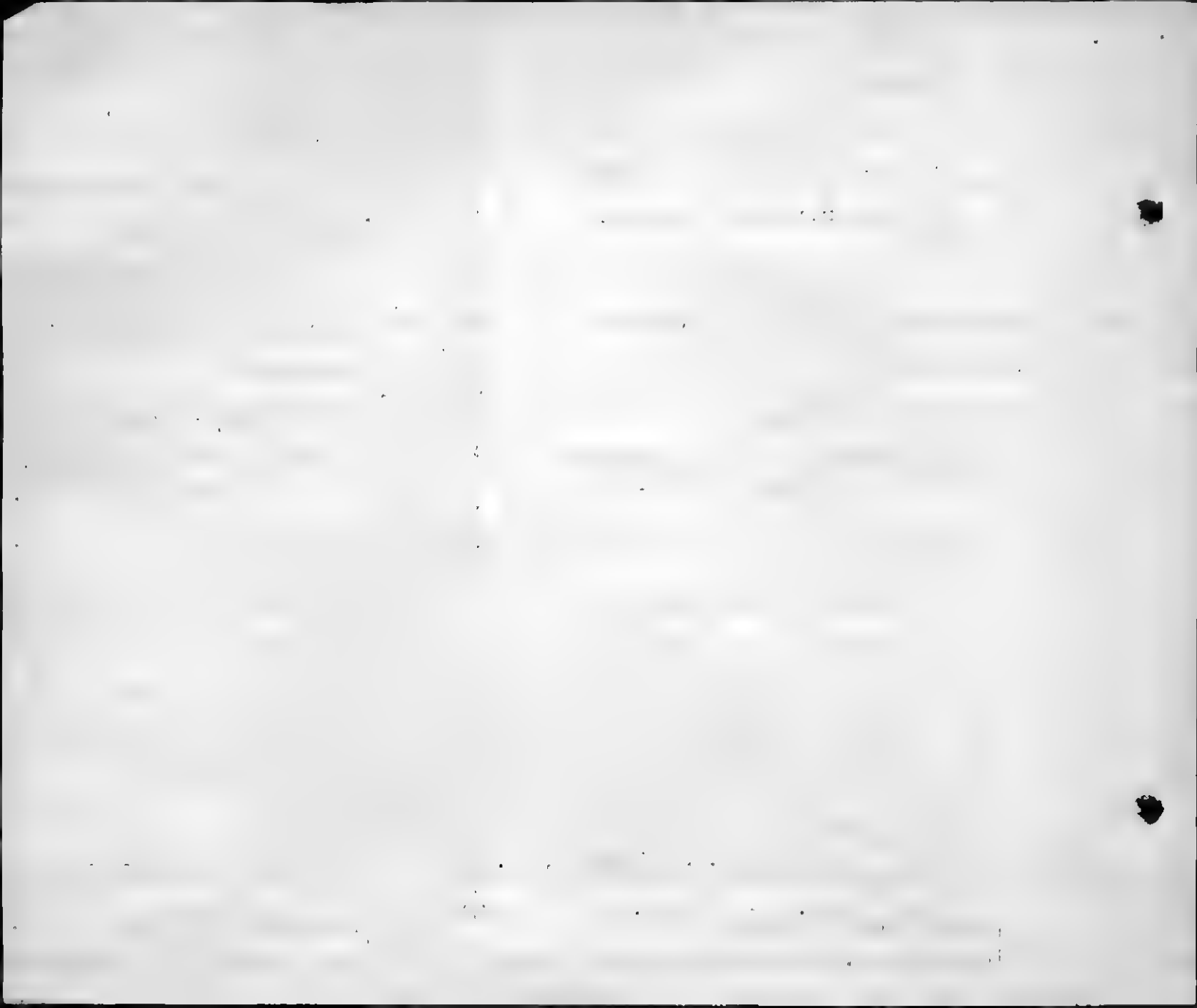
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN 1b <u>XXX</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Magnolia Nursing Home</u> <u>Prince George's General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marlowe Heights</u> d. STREET ADDRESS <u>5930 28th. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lawrence F. Carr</u> | | | | | | 4. DATE OF DEATH Last <u>12</u> Month <u>26</u> Day <u>1965</u> | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>22 June 1894</u> | | 9. AGE (in years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u> </u> | |
| 13. FATHER'S NAME <u>William Carr</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Nota Hayes</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | | 17. INFORMANT <u>Leonard R. Carr- Same as Item #2</u> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Carcinoma of prostate gland</u> DUE TO (c) <u> </u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>over 1 yr.</u> <u>over 1 yr.</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> Address (Street, city, town, or county) <u> </u> <u>12-27-65</u> | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Dec. 29-1965</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Washington DC</u> | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661-Good Hope RD SE Wash DC</u> | | | | | | 24a. REC'D BY REGISTRAR DATE <u>28 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill | |
| c. LENGTH OF STAY IN 1b DOA | | d. STREET ADDRESS 7506 Oxon Hill Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Guy W. S. Castle JR. | | 4. DATE OF DEATH Month 12 Day 5 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 22 March 1915 |
| 9. AGE (In years last birthday) 50 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) White Historian Self employed | | 11. BIRTHPLACE (State or foreign country) Washington D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Harriet B. Castle Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus 4201 DUE TO (b) From coronary artery occlusion DUE TO (c) From Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | |
| SIGNATURE John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED 12-6-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-8-65 | 23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Em. | 23d. LOCATION (City, town or county) (State) Oxon Hill Md. |
| 24. FUNERAL DIRECTOR W.W. Chambers & Son, 517-11th St. S.E. | | 25a. REC'D BY REGISTRAR DEC 9 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 3 hr. 16 min. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | | | e. STREET ADDRESS 1711 Montgomery Road | | | | | |
| 3. NAME OF DECEASED (Type or print) Twin A Baby | | First Boy | | Middle Chase | | Last Chase | | 4. DATE OF DEATH December 24 19 65 | | Month December Day 24 Year 19 65 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 24, 1965 | | 9. AGE (in years last birthday) 3 yrs. | | 10. UNDER 1 YEAR Months 3 Days 16 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Oliver Chase | | | | | | 14. MOTHER'S MAIDEN NAME Marilyn Ruth Silva | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral atelectasis DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 24 / 1965 to Dec 24 / 1965 , that (I) (we) last saw the deceased alive on Dec 24 / 1965 , and that death occurred at 6:39 M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | | 22b. DATE SIGNED 12/24/65 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Iradi Mandavi, M.D. | | | | | | 22d. ADDRESS 6821 Riverdale Rd. Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE THEREOF 1/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp. | | | | 23d. LOCATION (City, town or county) (State) Cheverly, Maryland | | | |
| 24. FUNERAL DIRECTOR William A. Parker | | | | | | 25a. REC'D BY REGISTRAR IAN 12 1966 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| 26. ASSISTANT ADMINISTRATOR William A. Parker, Assistant Administrator | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 16791 CERTIFICATE OF DEATH 20586 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 1. PLACE OF DEATH a. COUNTY Prince George's 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 hr. 40 min. </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 3. NAME OF DECEASED (Type or print) "B" Baby 4. DATE OF DEATH December 24 19 65 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 8. DATE OF BIRTH December 24, 1965 9. AGE (In years last birthday) 10 40 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- 10b. KIND OF BUSINESS OR INDUSTRY -- </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland 12. CITIZEN OF WHAT COUNTRY? USA </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 13. FATHER'S NAME William Oliver Chase 14. MOTHER'S MAIDEN NAME Marilyn Ruth Silva </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) -- 16. SOCIAL SECURITY NO. -- </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 17. INFORMANT Address </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelectasis (Bilateral)</i> DUE TO (b) <i>Prematurely</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 21. I certify that (I) (this hospital) attended the deceased from <i>Dec 24/65</i> to <i>Dec 24</i> 19 <i>65</i>, that (I) (we) last saw the deceased alive on <i>Dec 24</i> 19 <i>65</i>, and that death occurred at <i>6:40 PM</i> from the causes and on the date stated above. </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 22a. SIGNATURE <i>William A. Parker</i> 22b. DATE SIGNED 12/24/65 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 22c. PHYSICIAN'S NAME (Type) Iradj Mahdavi, M.D. 22d. ADDRESS 6821 Riverdale Rd. Riverdale, Md. </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation 23b. DATE THEREOF 1/8/66 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp. 23d. LOCATION (City, town or county) (State) Cheverly, Maryland </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 24. FUNERAL DIRECTOR <i>William A. Parker</i> 25a. REC'D BY REGISTRAR JAN 12 1966 </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> 25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i> </div> | | | | | | | | | |



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FOR STATE
HEALTH DEPT.

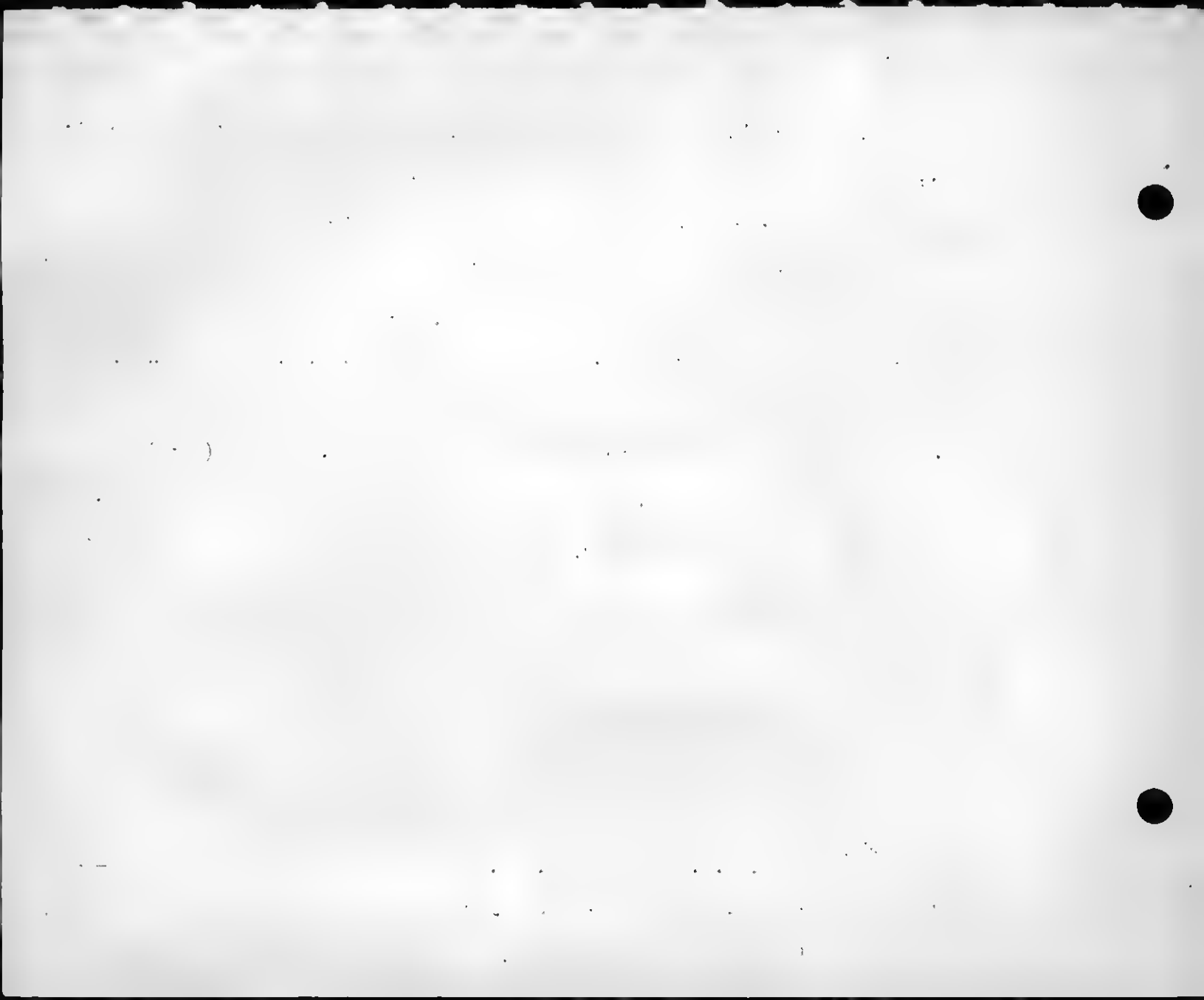
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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16792

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City | |
| c. LENGTH OF STAY IN 1b DOA | | d. STREET ADDRESS 4003 Bunker Hill Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Raymond Augustine Chism | | 4. DATE OF DEATH Month Day Year 12 8 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 Jan. 1898 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 10b. KIND OF BUSINESS OR INDUSTRY Iron Co. | | 11. BIRTHPLACE (State or foreign country) Washington D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frederick Johnson Chism | |
| 14. MOTHER'S MAIDEN NAME Clara ? | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | |
| 16. SOCIAL SECURITY NO. 579-14-6215A | | 17. INFORMANT Lena Chism Same as #2 (wife) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right coronary artery occlusion 4x101 DUE TO (b) Arteriosclerotic heart disease over 6 months DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-9-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/13/65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons | | 25. REGISTRAR'S SIGNATURE Charles Judge | |
| ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 16 1965 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | | | c. LENGTH OF STAY IN 1b 11 DAYS | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MCLEAN 834.5 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL | | | | d. STREET ADDRESS 1737 SUSQUEHANNOCK DRIVE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JAMES EUGENE CHRISTENSEN | | | | 4. DATE OF DEATH DECEMBER 23 1965 | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 APRIL 1920 | | 9. AGE (In years last birthday) 45 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER US AIR FORCE | | | | 10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE | | | | 11. BIRTHPLACE (County & State, or foreign country) IOWA | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME JAMES CHRISTOPHER CHRISTENSEN | | | | 14. MOTHER'S MAIDEN NAME ANNA F. SORENSEN | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO. 1940 - 1965 482-09-2503 | | | | 17. INFORMANT WIFE | | | |
| | | | | | | | | Address SAME AS ITEM #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma 1909 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12 Dec, 1965, to 23 Dec, 1965, that (I) (we) last saw the deceased alive on 23 Dec, 1965, and that death occurred at 0900 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE R.G. Pearce | | | | 22b. DATE SIGNED 23 Dec 65 | | | | | | | |
| 22c. PHYSICIAN NAME (Type) RONALD D PEARCE | | | | 22d. ADDRESS USAF HOSP, ANDREWS AIR FORCE BASE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-27-65 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers & Co. 517-11th St. S.E. | | | | 25a. REC'D BY REGISTRAR DEC 28 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

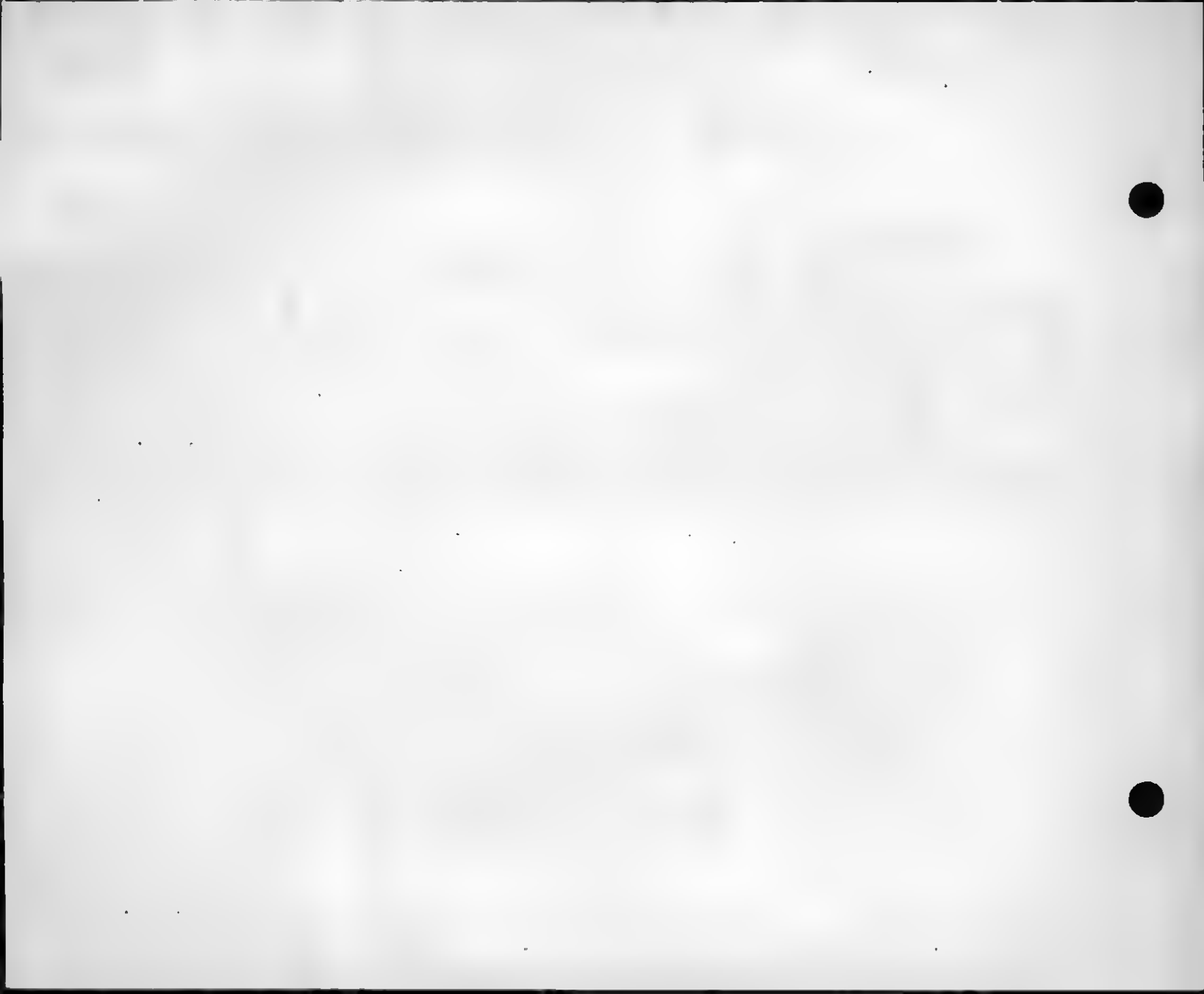
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

16794

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

176

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | d. STREET ADDRESS 6417 Landover Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Guy | | First Middle Last M Clark | | 4. DATE OF DEATH Dec., 15 th = 1965 | | Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 29 May 1895 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor | | 10b. KIND OF BUSINESS OR INDUSTRY Railway Co | | 11. BIRTHPLACE (County & State, or foreign country) Maine | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Omar Clark | | | | 14. MOTHER'S MAIDEN NAME Ellen M. Holder | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital records | | Address Cheverly, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, acute</i> DUE TO (b) <i>Pulmonary embolism, acute</i> DUE TO (c) <i>Empyema of lungs advanced</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs 24 hrs 6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/8, 1965 to 12/15, 1965 that (I) (we) last saw the deceased alive on 12/15, 1965 and that death occurred at 6:20 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Norman D. O'neal | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/15/65 | |
| 22c. PHYSICIAN'S NAME (Type) Norman D. O'neal | | | | 22d. ADDRESS 3503 Penny St Mt Rainier | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 17, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City, town or county) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 20 1965 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

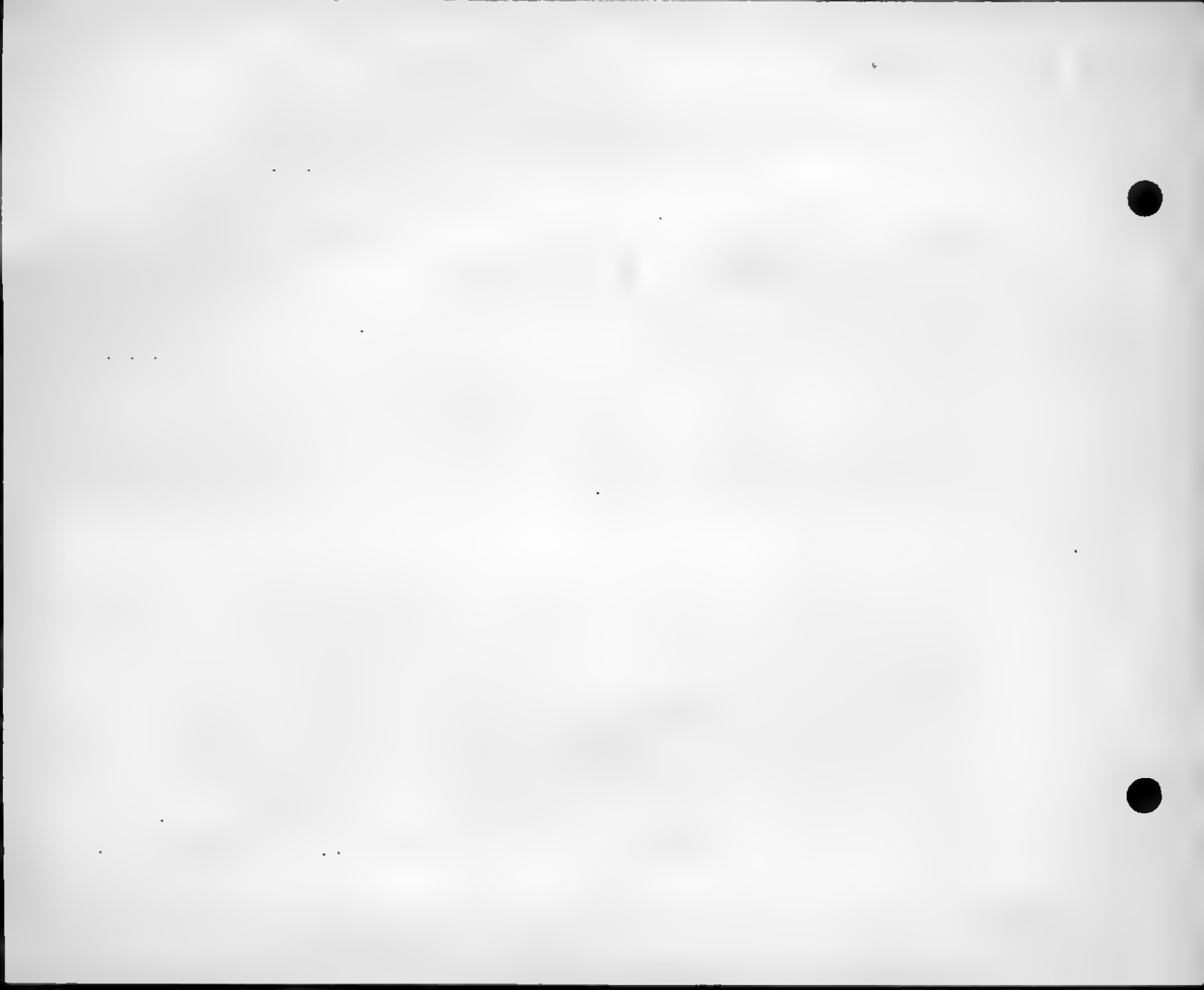
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1814 29th Street d. STREET ADDRESS 1814 29th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Stephen Middle Charles Last Clark | | 4. DATE OF DEATH Month December Day 16 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 3, 1965 |
| 9. AGE (In years last birthday) 15 yrs. | | 10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. | 11. IF UNDER 24 HRS. Months 15 Days 15 Hours 15 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Clark | | 14. MOTHER'S MAIDEN NAME Carol Oden | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Charles Clark father same as 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 65 , to 12/16 , 19 65 , that (I) (we) last saw the deceased alive on 12/16 , 19 65 , and that death occurred at 2:10 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Max M. Herzberg | | 22b. DATE SIGNED 12/17/65 | |
| 22c. PHYSICIAN'S NAME (Type) Max M. Herzberg | | 22d. ADDRESS 7016 Greig St. Seat Pleasant, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-18-65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR See Funeral Home | | 25a. REC'D BY REGISTRAR DEC 22 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN ID <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Box 4217</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James H Coates</u> First Middle Last | | | | | | 4. DATE OF DEATH <u>December 2 1965</u> Month Day Year | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 26, 1927</u> | | 9. AGE (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | 13. FATHER'S NAME <u>John Coates</u> 14. MOTHER'S MAIDEN NAME <u>Grace Smith</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>216 22 0323</u> 17. INFORMANT <u>Evangelina Coates Upper Marlboro, Md.</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction (left temporal lobe)</u> 2x DUE TO (b) <u>Cerebral Thrombosis (left anterior cerebral artery)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Cerebral Arteriosclerosis</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30</u> , 19 <u>65</u> , to <u>Dec. 2</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 2</u> , 19 <u>65</u> , and that death occurred at <u>11:00</u> <u>PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Carolina Paredes Mamlapaz, M.D.</u> | | | | | | 22b. DATE SIGNED <u>12-3-65</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Carolina Paredes Mamlapaz, MD.</u> | | | | | | 22d. ADDRESS <u>Prince George's Genl. Hosp. Cheverly, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>12-7-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Methodist</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Crofton Md.</u> | |
| 24. FUNERAL DIRECTOR <u>William H 4339 Hunt Rd N.E.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |



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VR A15 (4)
20M 1/65

16797

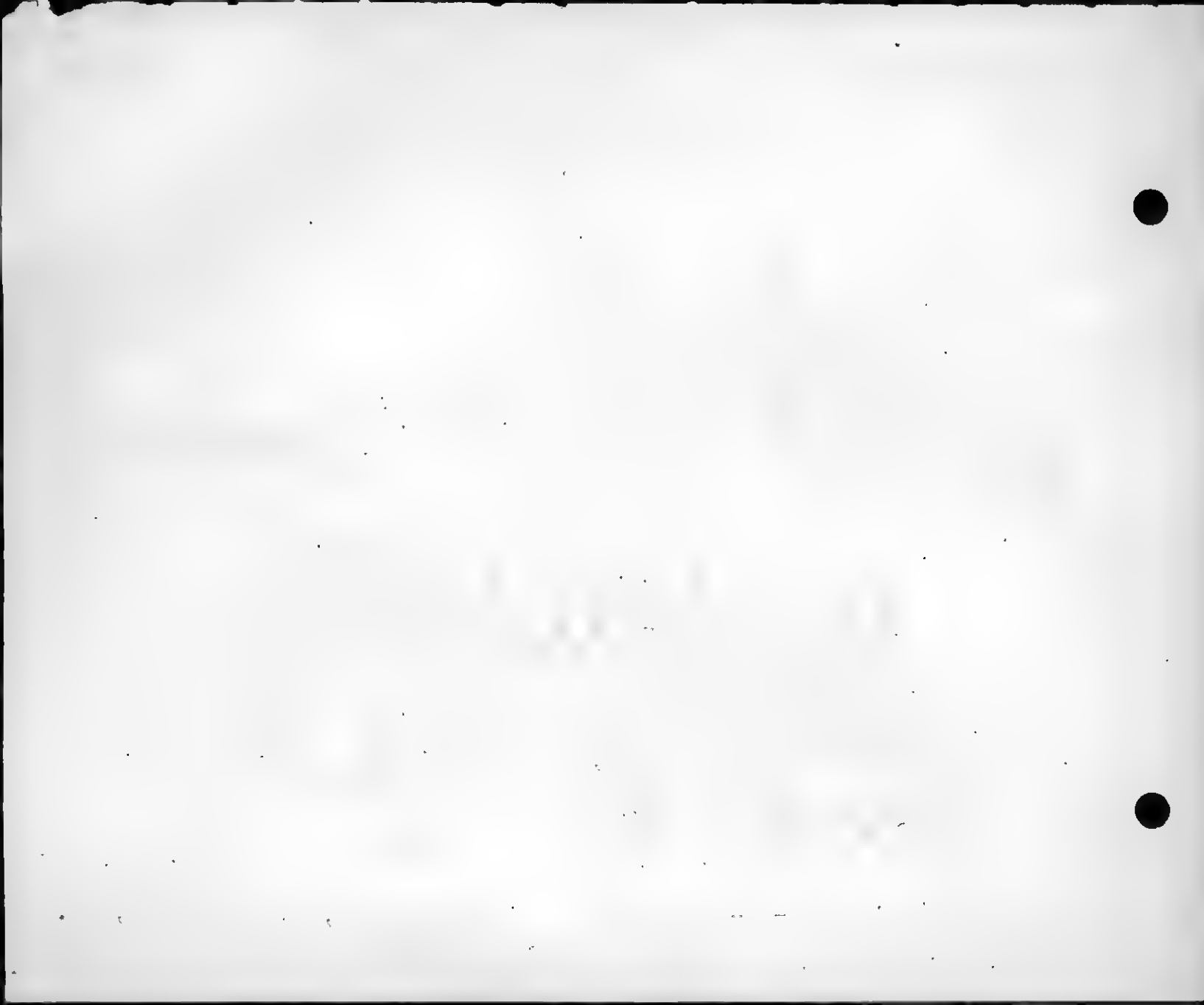
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montgomery</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | |
| c. LENGTH OF STAY IN 1b <u>15 months</u> | | d. STREET ADDRESS <u>6526 Western Ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hyattsville Nursing Home Rggs Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Corrado</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1965</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 2, 1981</u> |
| 9. AGE (in years last birthday) <u>84</u> yrs. | | 10. FINDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Providence town, Mass</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Manuel Cook</u> | | 14. MOTHER'S MAIDEN NAME <u>Gloria Perry</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>579-01-4883</u> | |
| 17. INFORMANT <u>Elizabeth Amerikan</u> | | Address <u>6526 Western Ave, Chevy Chase, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection</u> <u>+200</u> DUE TO (b) <u>Pneumonia & renal trapping</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>generalized arteriosclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arteriosclerosis Heart Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>65</u> to <u>Dec.</u> , 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>65</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Lester S. Blumenthal</u> | | 22b. DATE SIGNED <u>12-21-65</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LESTER S. BLUMENTHAL</u> | | 22d. ADDRESS <u>5315 CONN. AVE NW WASH-D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-23-1965</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Fowler Inc</u> | | 25a. REC'D BY REGISTRAR <u>DEC 27 1965</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | | 25c. ADDRESS <u>5130 21st Ave. NW Wash, D.C.</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

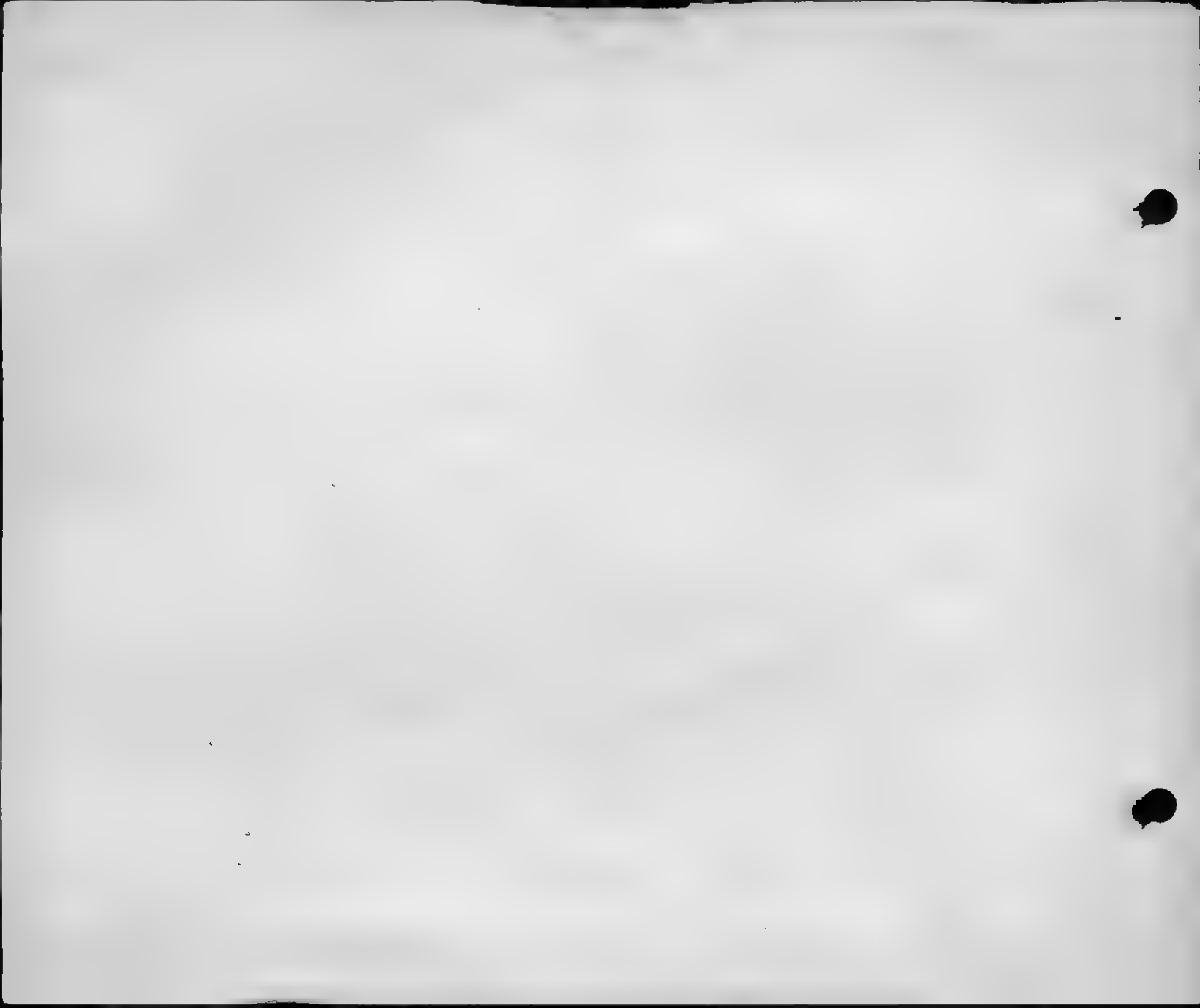
CERTIFICATE OF DEATH

16798

281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

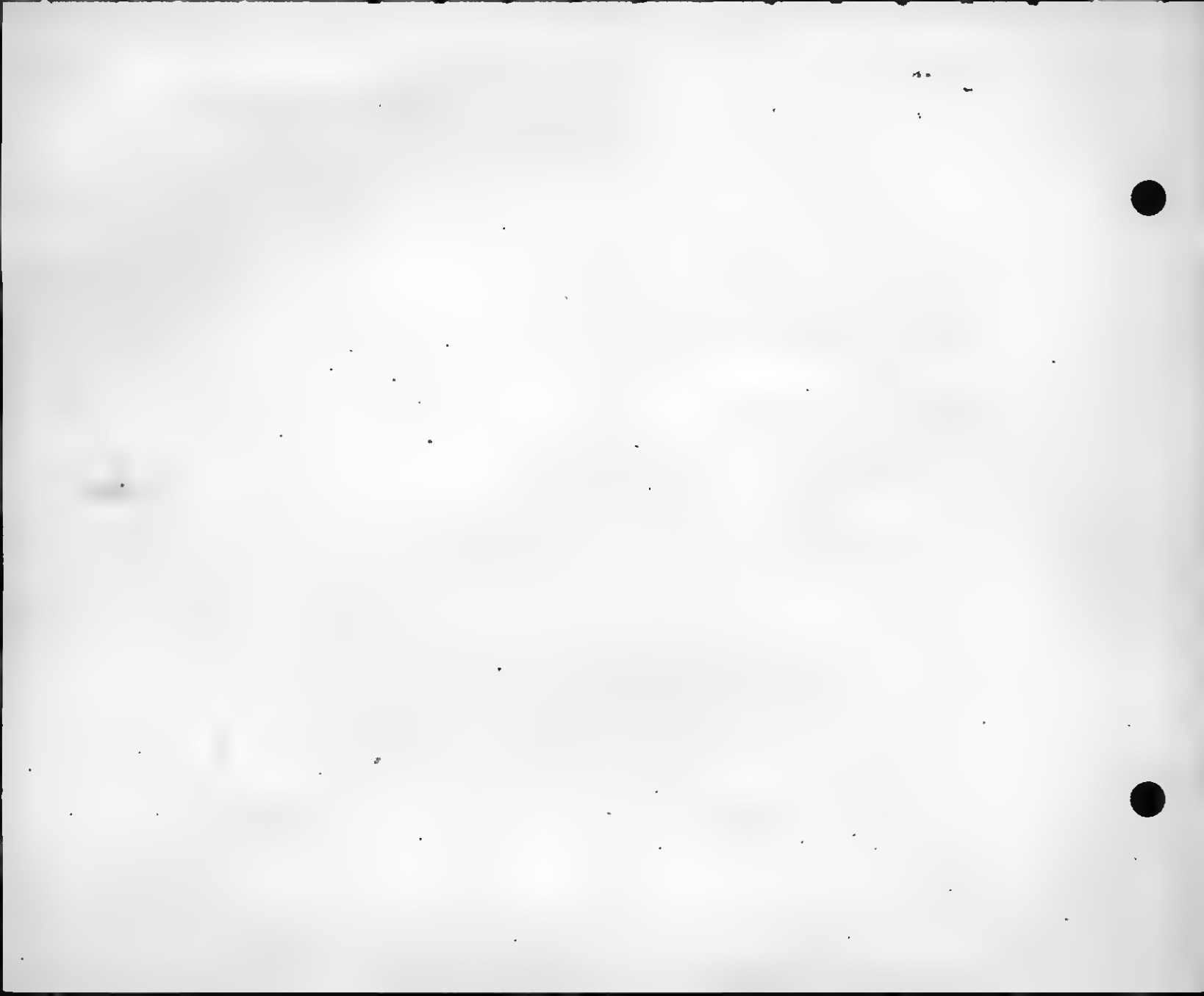
| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u> c. LENGTH OF STAY IN b. <u>10 MOS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3405 LORRING DRIVE</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u> d. STREET ADDRESS <u>3405-LORRING DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CATHERINE A CREAMER</u> | | 4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>17</u> Year <u>1965</u> | | 5. SEX <u>FEMALE</u> | | | |
| 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 9, 1896</u> | | 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - CLERK. U.S. CENSUS BUREAU</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. CENSUS BUREAU</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MIDLAND, MD.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>RICHARD JOSEPH CREAMER</u> | | 14. MOTHER'S MAIDEN NAME <u>ROSE ANNE McVEIGH</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>ROSHAEEN B. SAN FELLIPO - #2 above</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tumor of Left Kidney</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY <input checked="" type="checkbox"/> INTENDED YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>17 Dec</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> , 19 <u>65</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Warren B. Birch</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>WARREN B. BIRCH</u> | | 22d. ADDRESS <u>405 A St S.E. Wash D.C.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>12/20/65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | | | |
| 23d. LOCATION (City, town or county) (State) <u>SUITLAND, MD.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>JAS. T. RYAN, INC.</u> ADDRESS <u>317 PA. AVE S.E. DC</u> | | | | | |
| 25a. REC'D BY REGISTRAR <u>DEC 20 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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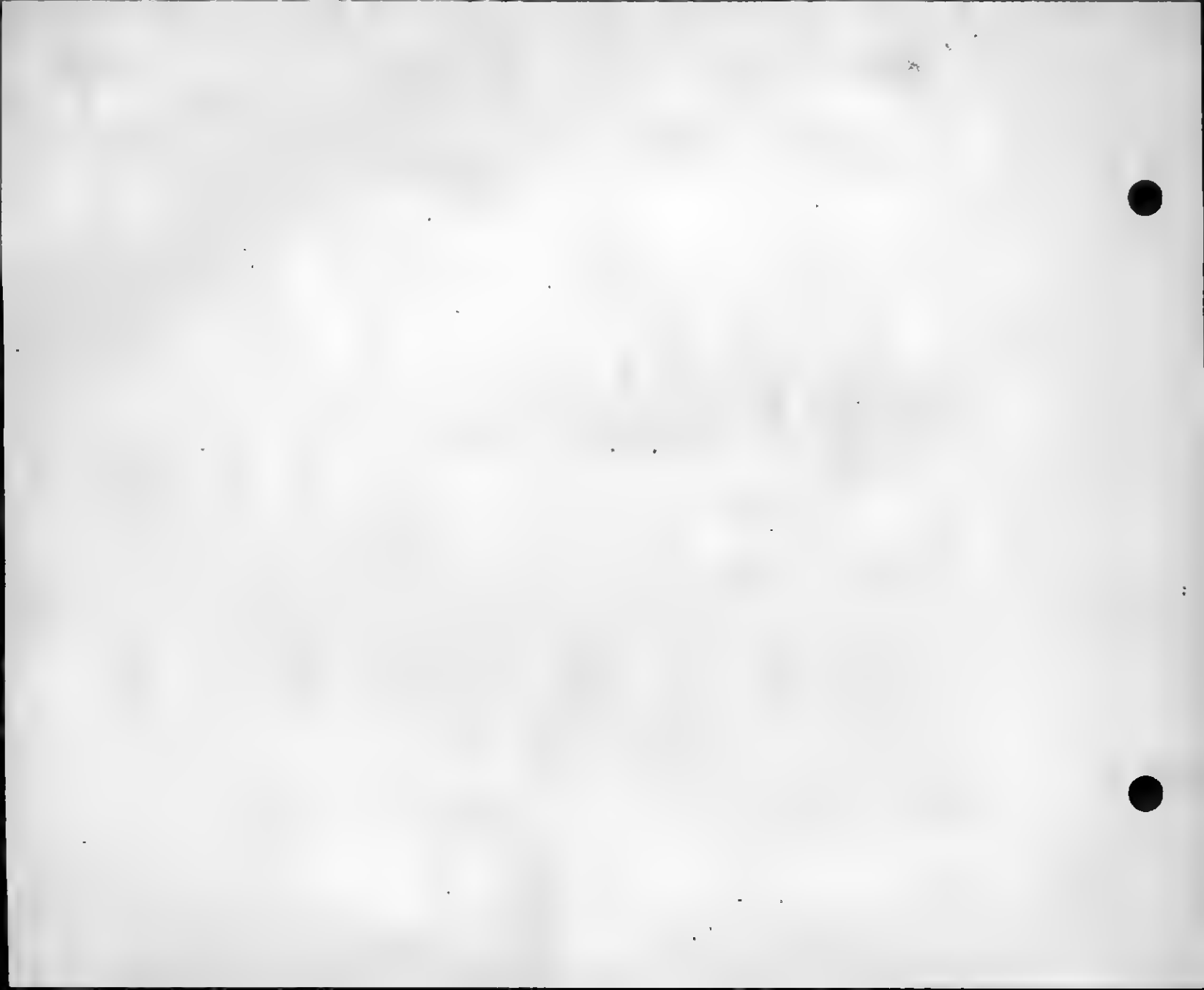
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 16799 CERTIFICATE OF DEATH 2181 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN ID 1hr 57mi d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DISTRICT OF COLUMBIA COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 4740 BENNING RD SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE CROCHERON RHONDA DENISE 4. DATE OF DEATH Month Day Year Dec 16 19 65 | | | | | | 5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 16 Dec 1965 9. AGE (in years last birthday) 16 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n/a 10b. KIND OF BUSINESS OR INDUSTRY n/a 11. BIRTHPLACE (County & State, or foreign country) Prince George's Md 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME RONALD CROCHERON | | | | | | 14. MOTHER'S MAIDEN NAME JOYCE W SINGLETARY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. None 17. INFORMANT FATHER Address SAME AS ITEM #2 | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 16, 19 65 to Dec 16, 19 65, that (I) (we) last saw the deceased alive on Dec 16, 19 65, and that death occurred at 7:25 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Philip Steiner 22c. PHYSICIAN'S NAME (Type) PHILIP STEINER, CAPT, USAF, MC 22d. ADDRESS USAF HOSP, ANDREWS AFB, MD | | | | | | 22b. DATE SIGNED Dec 16, 1965 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-21-65 23c. NAME OF CEMETERY OR CREMATORY Arlington National 23d. LOCATION (City, town, or county) (State) Arlington Virginia | | | | 24. FUNERAL DIRECTOR W. W. Chambers & Inc. 517-11 th St. N.E. DEC 27 1965 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16800
CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Prince George | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Hgths | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Hgths | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | d. STREET ADDRESS 2345. Kenton Pl | |
| 3. NAME OF DECEASED (Type or print) Robert H. Croggon | | 4. DATE OF DEATH 12. 15 1965 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7.8.1892 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Taxi | |
| 11. BIRTHPLACE (County & State, or foreign country) D C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Henry Croggon | | 14. MOTHER'S MAIDEN NAME Catherine Chase | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579.22.5036 | |
| 17. INFORMANT Address Maude E. Croggon 2345. Kenton Pl | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Ac. Myocardial Failure DUE TO (b) C. U. R. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Larynx | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1946, 19, to 12-15, 1965, that (I) (we) last saw the deceased alive on 12-14, 1965, and that death occurred at 5:30 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Bernard Katzen | | 22b. DATE SIGNED 12-15-65 | |
| 22c. PHYSICIAN'S NAME (Type) BERNARD KATZEN | | 22d. ADDRESS 2545 - New York Rd. S.E. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12.18.65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 23d. LOCATION (City, town or county) (State) Washington D C | |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E | | 25a. REC'D BY REGISTRAR DEC 20 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

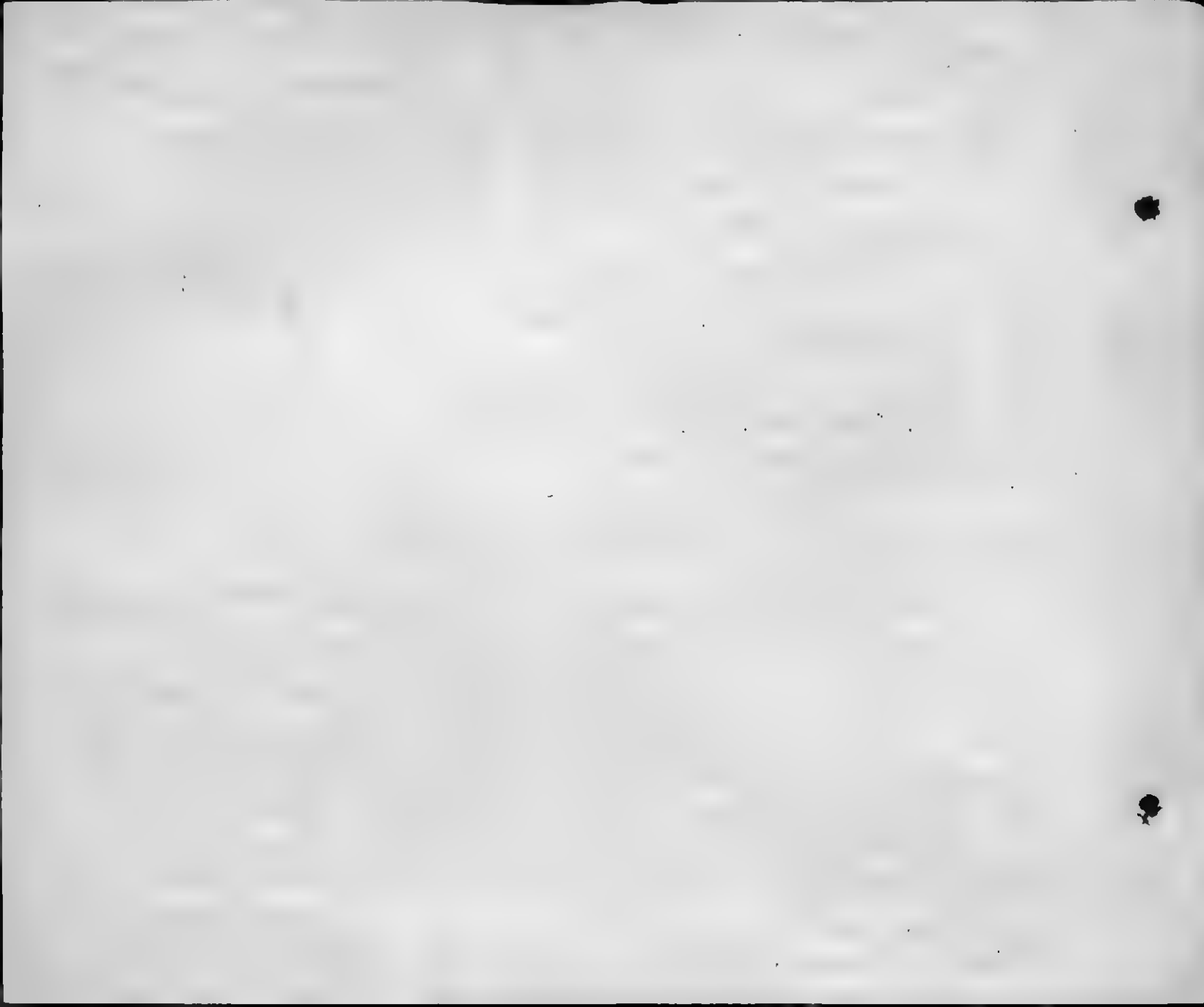
16801

CERTIFICATE OF DEATH

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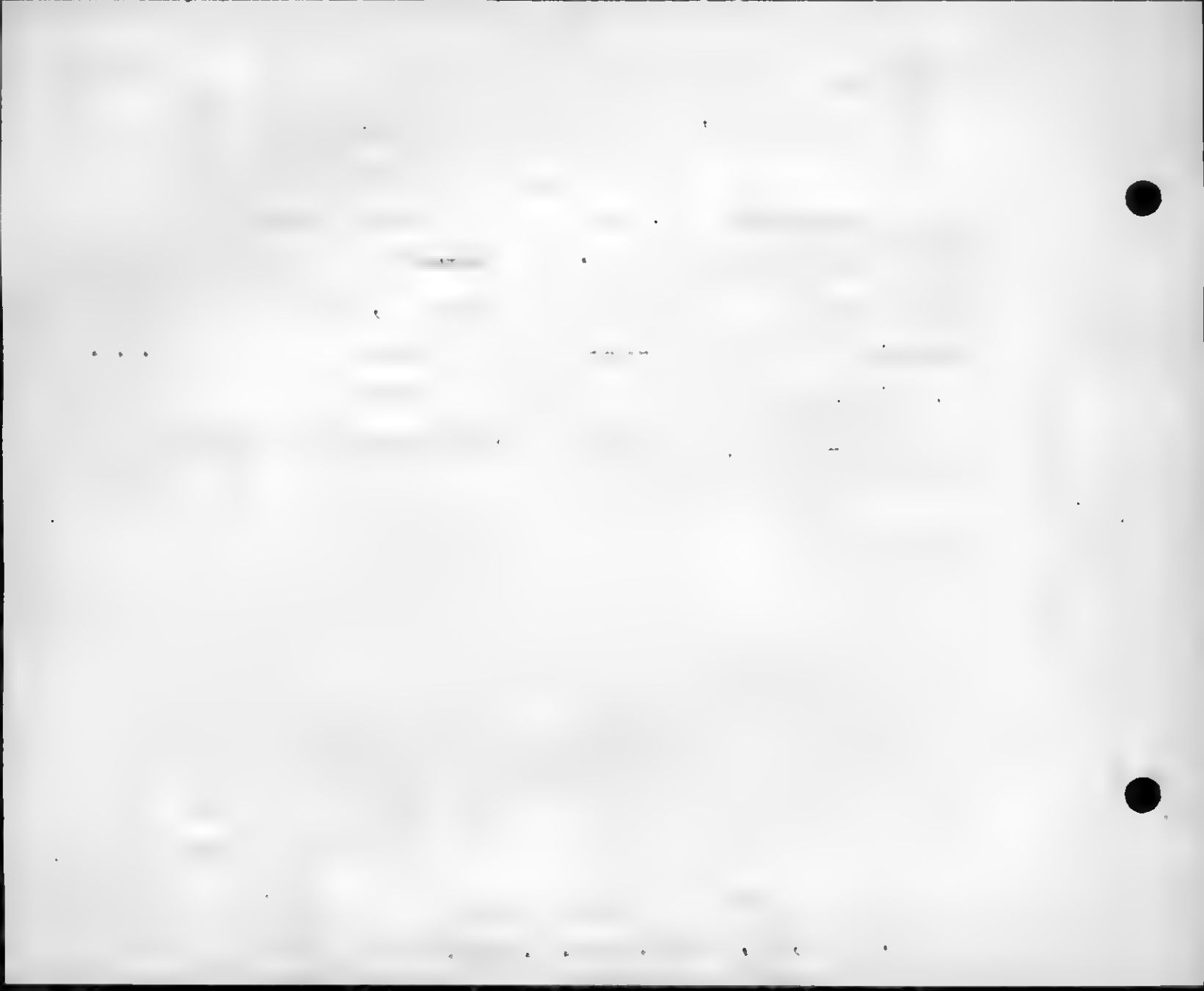
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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR 4922 LA SALLE</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u> </u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1000 CTIS STREET NE</u> d. STREET ADDRESS <u>41X-5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>FRANK BERNARD CURRAN</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1965</u> | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-15-1940</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (in years last birth -y) <u>75</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High way Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Economist</u> | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>M. S. H.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>JAMES CURRAN</u> 14. MOTHER'S MAIDEN NAME <u>MARY AGNES BRADY</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 16. SOCIAL SECURITY NO. <u>577-66-3984</u> 17. INFORMANT <u> </u> Address <u> </u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Adenocarcinoma of sigmoid colon</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>65</u> to <u>12/22</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>65</u> and that death occurred at <u>9 PM</u> from the causes and on the date stated above | | | | | | 22a. SIGNATURE <u>John W Winkler Jr</u> 22b. DATE SIGNED <u>12/22/65</u> 22c. PHYSICIAN'S NAME (Type) <u>John W Winkler Jr</u> 22d. ADDRESS <u>5800 10th St Hyattsville Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> 23b. DATE THEREOF <u>12-27-65</u> 23c. NAME OF CEMETERY OR CREMATORY <u> </u> 23d. LOCATION (City, town or county) (State) <u> </u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>DEC 28 1965</u> | | | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16802
CERTIFICATE OF DEATH

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5807 Maryhurst Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Evelyn | | First Ko | | Last Damuth | | 4. DATE OF DEATH Month December Day 17 Year 19 65 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 11, 1881 | |
| 9. AGE (in years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months 84 | | IF UNDER 24 HRS. Days 84 | | Hours 84 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? Brittingham | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Donald Damuth 5807 Maryhurst Drive | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 11 days Several years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-6, 1965 to 12-17, 1965 , that (I) (we) last saw the deceased alive on 12-17, 1965 , and that death occurred at 12:35 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Paul Angus Devore | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Dec. 17, 1965 | |
| 22c. PHYSICIAN'S NAME (Type) Paul Angus Devore, M.D. | | | | 22d. ADDRESS 3415 Hamilton St. W. Hyattsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/20/65 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. Balto. | | | | 25a. REC'D BY REGISTRAR DEC 20 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

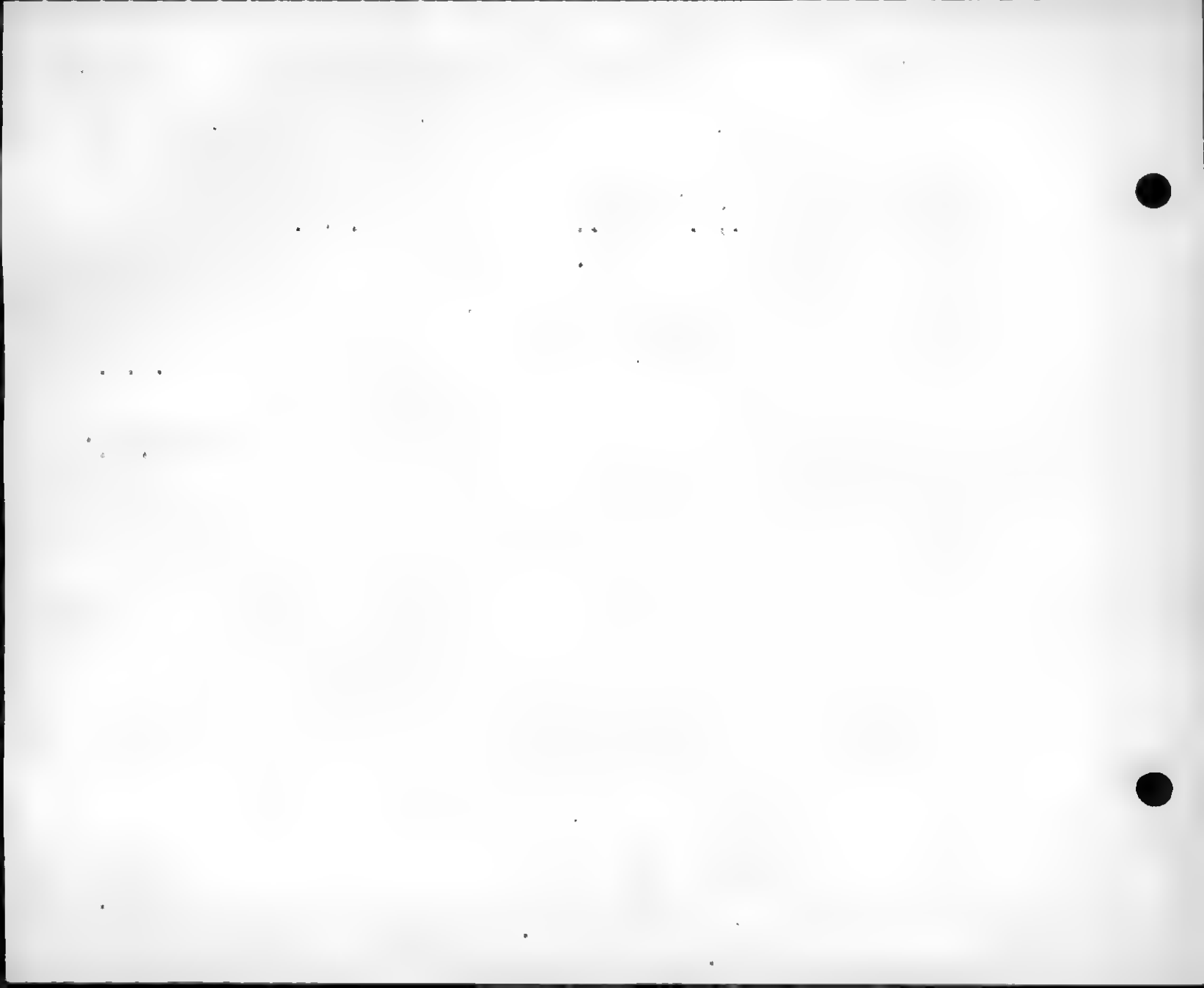
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1185

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1 PLACE OF DEATH a COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Prince George | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville | | c LENGTH OF STAY IN 1b West Hyattsville | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West Hyattsville Post Office 3504 Hamilton St., W. Hyatts. | | f STREET ADDRESS 5622 31st Ave. | |
| 3 NAME OF DECEASED (Type or print) First Mabel Middle B. Last Davey | | 4 DATE OF DEATH Month December Day 19 Year 1965 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH March 5, 1883 |
| 9 AGE (in years last birthday) 82 | | 10 IF UNDER 1 YEAR Months 12 Days 19 Hours 19 Min 65 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk | | 10b KIND OF BUSINESS OR INDUSTRY Bakery | |
| 11 BIRTHPLACE (State or foreign country) England | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Clifton (last name) Unknown | | 14 MOTHER'S MAIDEN NAME Unknown | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give year or dates of service) No | | 16 SOCIAL SECURITY NO 4904 Edgewood Rd. College Park, Md. | |
| 17 INFORMANT Raymond Davey | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC H.T. DISEASE (c) UNKNOWN | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John N. Kehoe M.D. EXAMINER'S NAME (Type) JOHN N. KEHOE | | 22. DATE SIGNED 12-20-65 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12/22/65 | |
| 23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d LOCATION (City or Town) (County) (State) Colmar Manor, Md. | |
| 24 FUNERAL DIRECTOR Nalley's | | ADDRESS Mt. Rainier | |
| Funeral Home Inc. | | DATE DEC 28 1965 | |
| 25a REG'D BY REGISTRAR Charles Judge | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

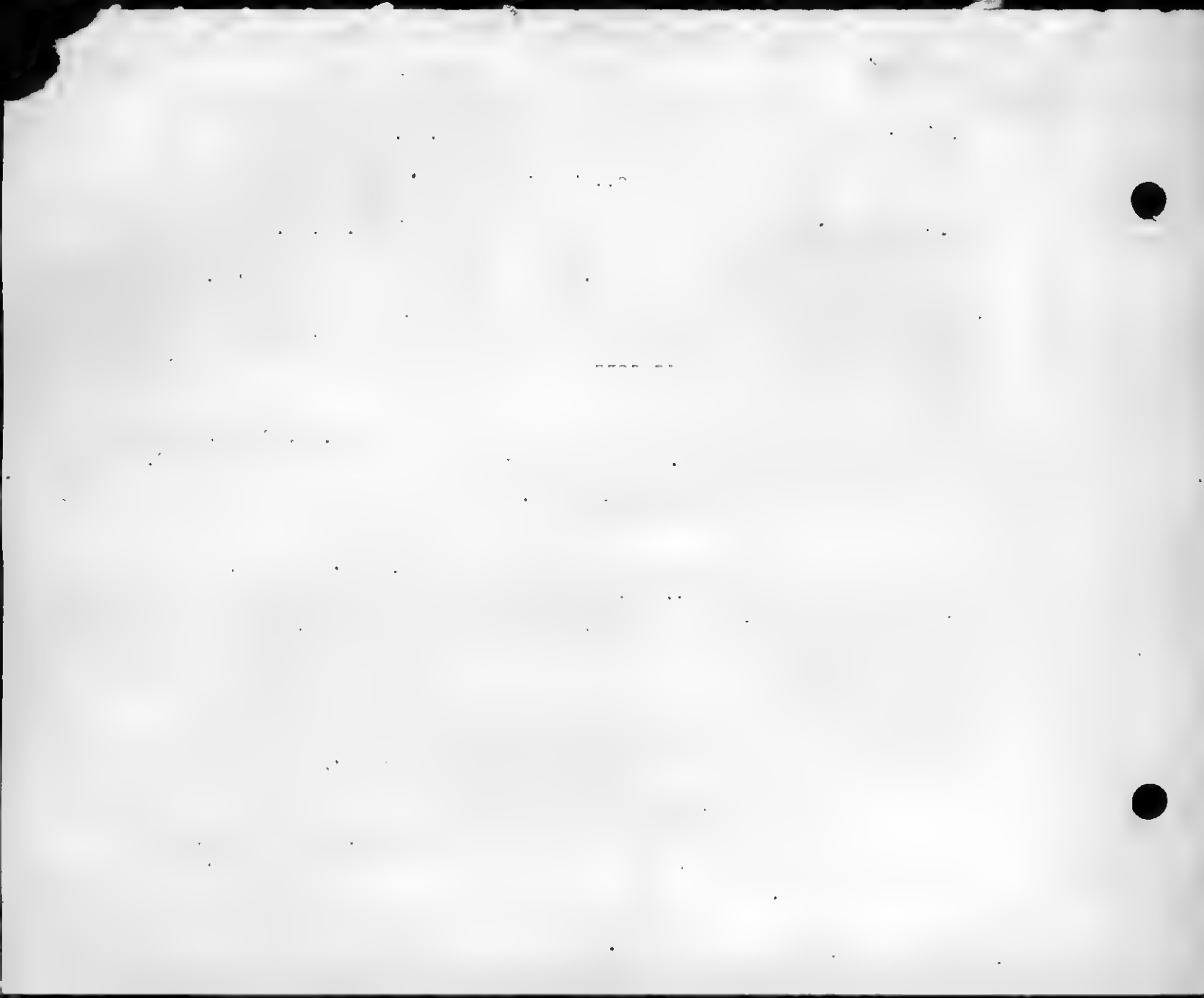
16804

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 8 mos., 28 dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2526 14th St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Leona B. Davis | | 4. DATE OF DEATH Month Dec Day 20 Year 1965 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/1/1897 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 9b. KIND OF BUSINESS OR INDUSTRY ----- | 9. AGE (in years last birthday) 68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 11. BIRTHPLACE (County & State, or foreign country) unknown | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Record Room | | Address D. C. General Hospital Washington, D. C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis with arterio- (c) sclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic pyelonephritis; recurrent cerebrovascular accidents | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/22 8:30 P. to 12/20 , 1965, that (I) (we) last saw the deceased alive on 12/20 1965 , and that death occurred at M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/20/65 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12-23-65 | 23c. NAME OF CEMETERY OR CREMATORY Harmon M. R. Cem. | 23d. LOCATION (City, town or county) (State) Suitland & Md. |
| 24. FUNERAL DIRECTOR Universal F. Home | | 25a. REC'D BY REGISTRAR DEC 27 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

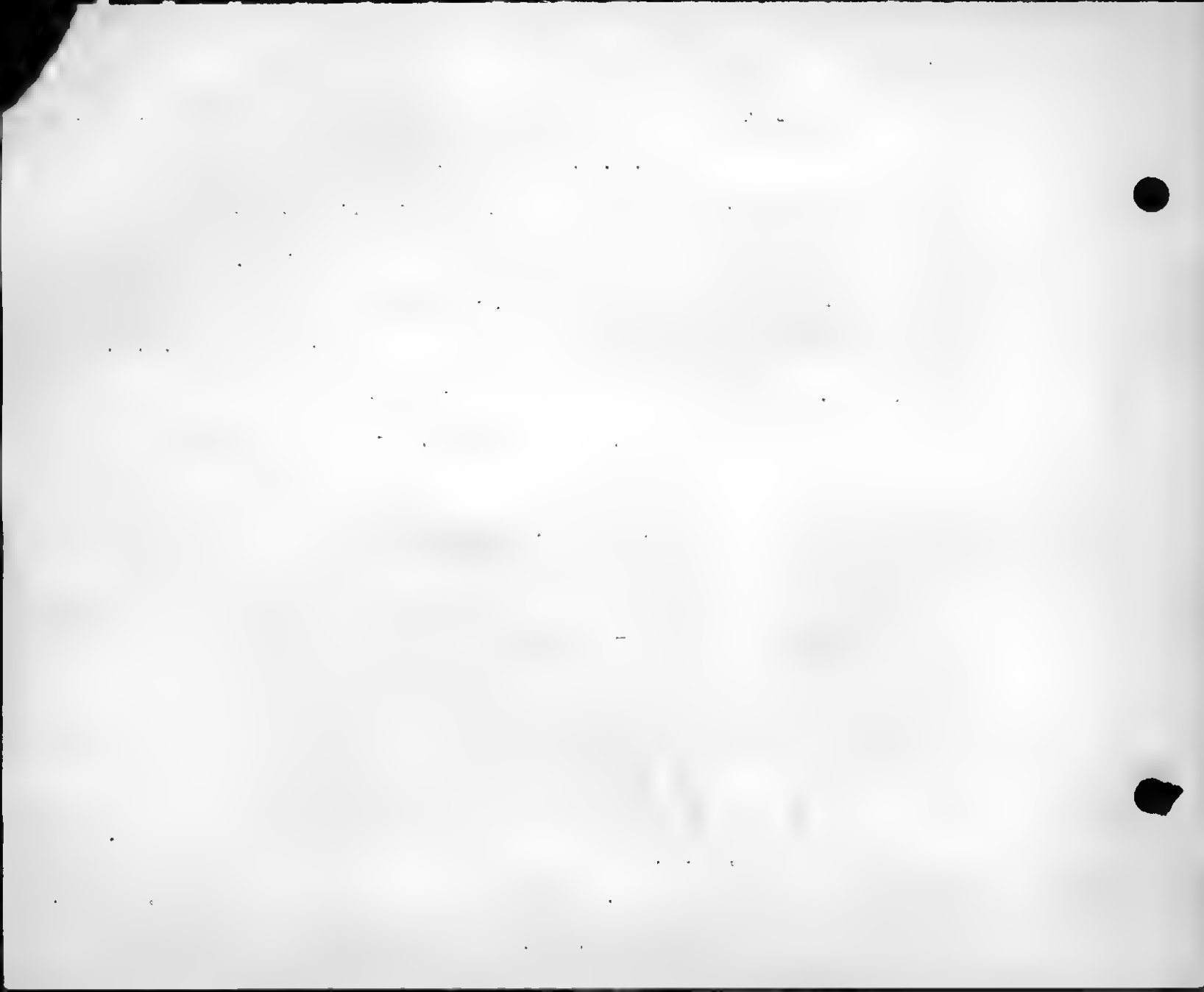
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VR AISME (5)
5M 1/65

16805

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D. O. A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| 3. NAME OF DECEASED (Type or print) First MARGARET Middle MARIE Last DAVIS | | 4. DATE OF DEATH Month DEC. Day 1, Year 19 65 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/1898 Sept 21, 1898 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alexander F. Dougaree | | 14. MOTHER'S MAIDEN NAME Clara Reeder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 217 14 7358B | |
| 17. INFORMANT Roland J. Davis | | Address Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) unknown | | | INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple myeloma - unknown | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12/1/65 | |
| EXAMINER'S NAME (Type) John Kehoe, M. D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/3/65 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 6 1965 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

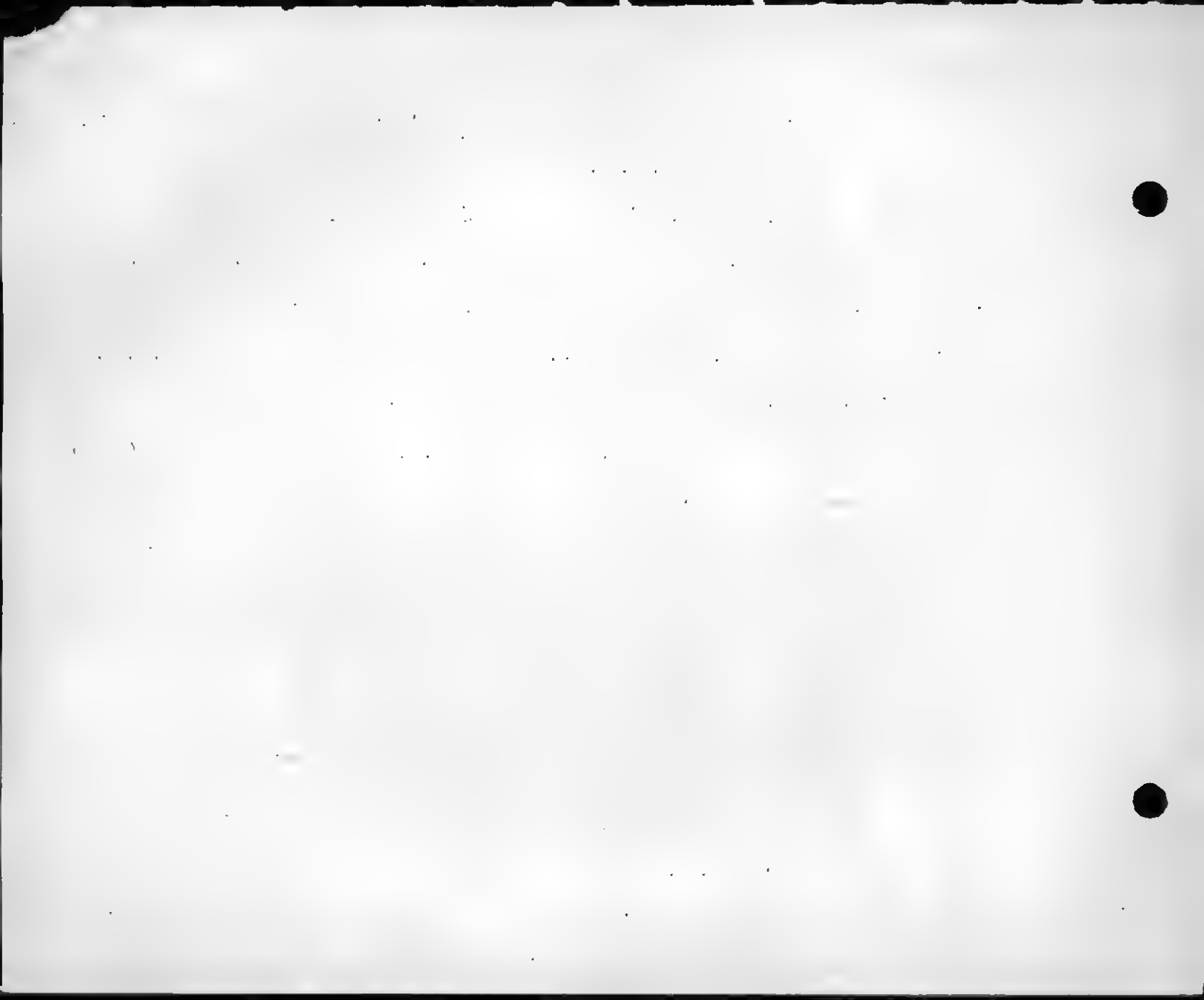
16806

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| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D. O. A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | |
| f. STREET ADDRESS 3522 54th Avenue Apt #1 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CORNELIUS PAUL DeBruyn Sr. | | 4. DATE OF DEATH Month Day Year Dec. 2, 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 3, 1900 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glazier | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile Co. | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Cornelius P. DeBruyn | | 14. MOTHER'S MAIDEN NAME Mary A. Cortwright | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 578 03 5165 | |
| 17. INFORMANT Emma F. DeBruyn Same as #2 (wife) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO (b) Arteriosclerotic heart disease over 4 years DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12/3/65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/4/65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 6 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN ID 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. STREET ADDRESS 5511 Alice Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Kenneth Last Deitz | | 4. DATE OF DEATH Month December Day 18 Year 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/2/43 |
| 9. AGE (In years last birthday) 22 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harvey Deitz | | 14. MOTHER'S MAIDEN NAME Jean Merkle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Harvey Deitz, Hyndman, Pa. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral (Infectious) Hepatitis 72x DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/13/65, 19 65, to 12/18, 19 65, that (I) (we) last saw the deceased alive on Dec. 18, 19 65, and that death occurred at 1:30M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Louis Mendel, M. D. | | 22b. DATE SIGNED 12/18/65 | |
| 22c. PHYSICIAN'S NAME (Type) C. Louis Mendel, M. D. | | 22d. ADDRESS 4410 74th Ave., Bellemead, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/ 20/65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery | | 23d. LOCATION (City, town or county) (State) Hyndman, Pa. | |
| 24. FUNERAL DIRECTOR F. Gaxch's Sons 4739 Balt. Ave, Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 22 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

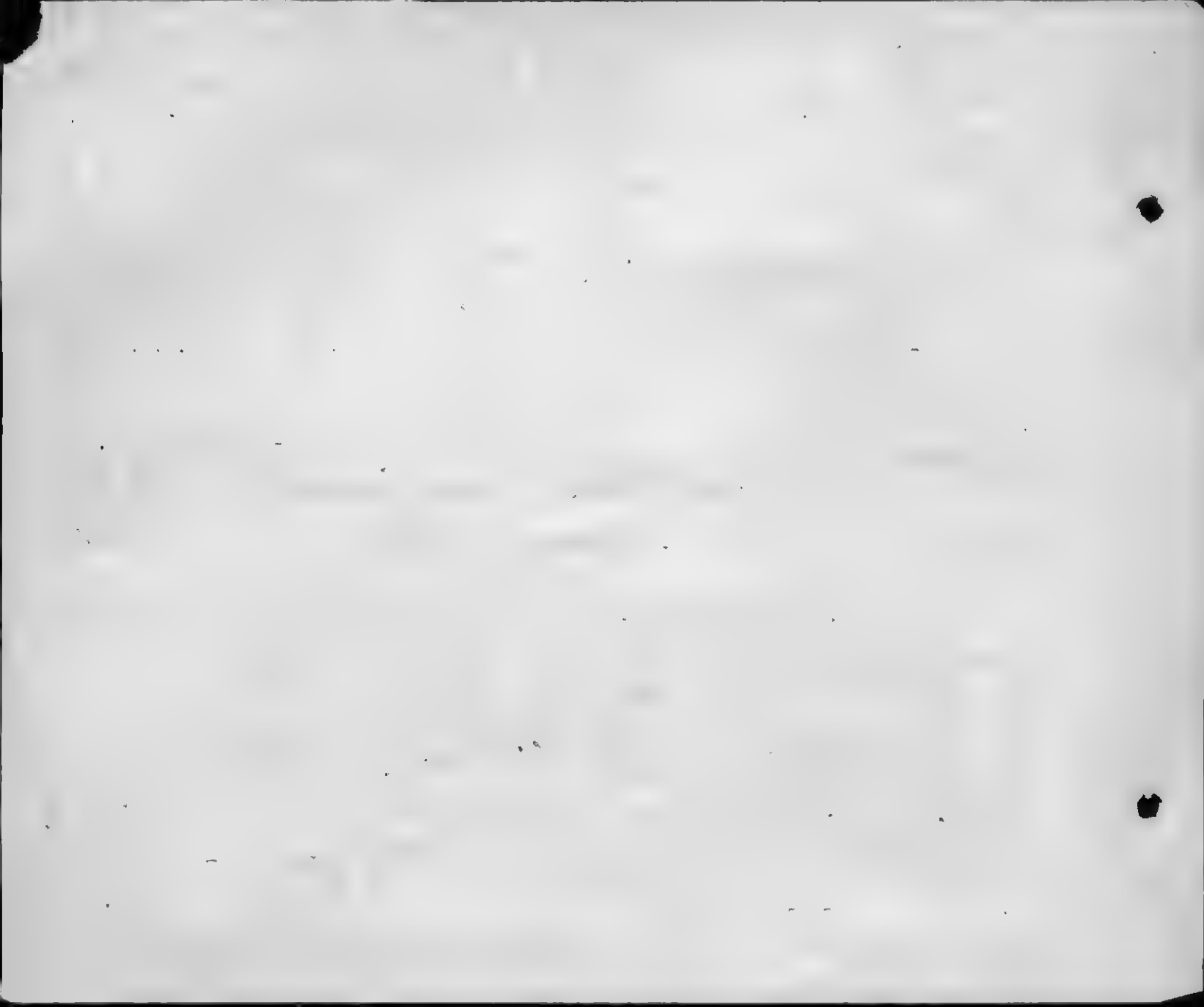
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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1 Riverdale</u> | | | d. STREET ADDRESS <u>6119 43rd Street</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6119 43rd Street</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Lillie M. Denekas</u> | | | 4. DATE OF DEATH <u>December 14 1965</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>July 17, 1906</u> | 9. AGE (In years last birthday) <u>59</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Secretary</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Anthony Denekas</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Lillie Kuhn</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | |
| 16. SOCIAL SECURITY NO. <u> </u> | | | | 17. INFORMANT <u>Lillian Hopkins</u> <u>3818-A W Street, S. E.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Ca Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Heart Dis.</u> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year: <u> </u> <u> </u> <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/17 1965</u> to <u>12/14 1965</u> that (I) (we) last saw the deceased alive on <u>12/13 1965</u> and that death occurred at <u>10:11 AM</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Rose S. Williams</u> | | 22b. DATE SIGNED <u>12/14/65</u> | | 22c. PHYSICIAN'S NAME (Type) <u>ROGER S. WILLIAMS M.D.</u> | |
| 22d. ADDRESS <u>35 NEW YORK AVE NW</u> | | 22e. CITY OR TOWN <u>Washington D. C.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-17-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | |
| 23d. LOCATION (City, town or county) <u>Washington</u> | | 23e. (State) <u>D. C.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wilhelm Funeral Home</u> | | 24a. ADDRESS <u>4308 Suitland Rd Suitland Maryland</u> | | 25a. REC'D BY REGISTRAR <u>DEC 17 1965</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. DATE <u>DEC 17 1965</u> | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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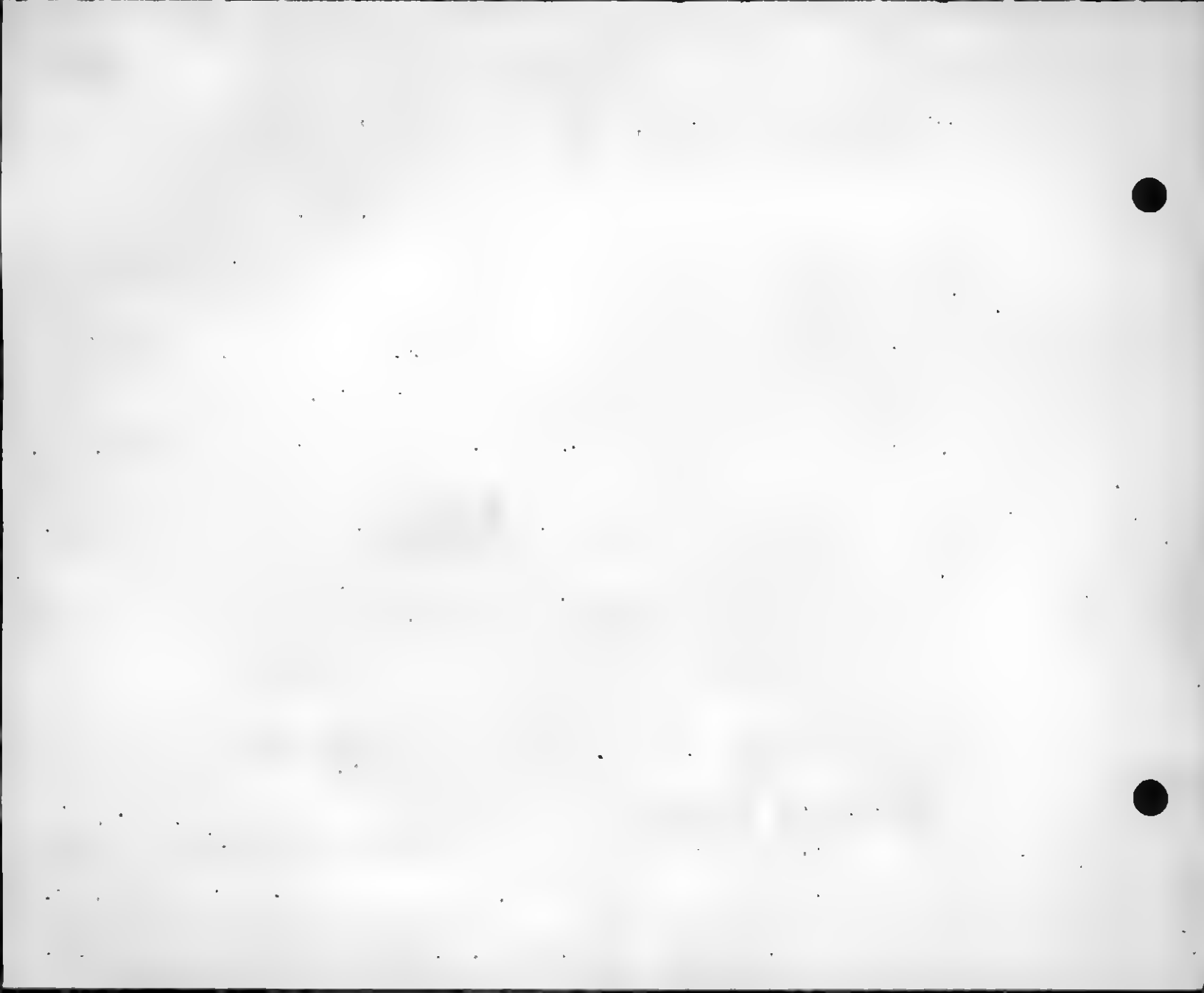
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

191

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>Brentwood</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> c. LENGTH OF STAY IN 1b <u>75 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____ | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) _____ d. STREET ADDRESS <u>4522 1/2 41st. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Dent</u> Last <u>Dent</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1965</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-27-1882</u> | 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (County & State, or foreign country) <u>Charlestown, West Va.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Matilda Wright</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>218-30-3667</u> | | 17. INFORMANT Address <u>Mrs. Lucille Quarles 4522 - 41st. Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia</u> (b) <u>Arteriosclerosis</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>3 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) (County) (State) _____ | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19<u>64</u> to <u>12-6</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>12-4</u>, 19<u>65</u>, and that death occurred at <u>LP</u> M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Leonard Hays</u> | | | 22b. DATE SIGNED <u>12-6-65</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Leonard Hays</u> | | | 22d. ADDRESS <u>5201 Baltimore Hyattsville Md.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-11-1965</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u> | | 23d. LOCATION (City, town or county) (State) <u>7601 - Sheriff Road, Md.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Washington Funeral Chapel 475 H. St. N. W.</u> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>DEC 13 1965</u> <u>Charles Judge</u> | | | |

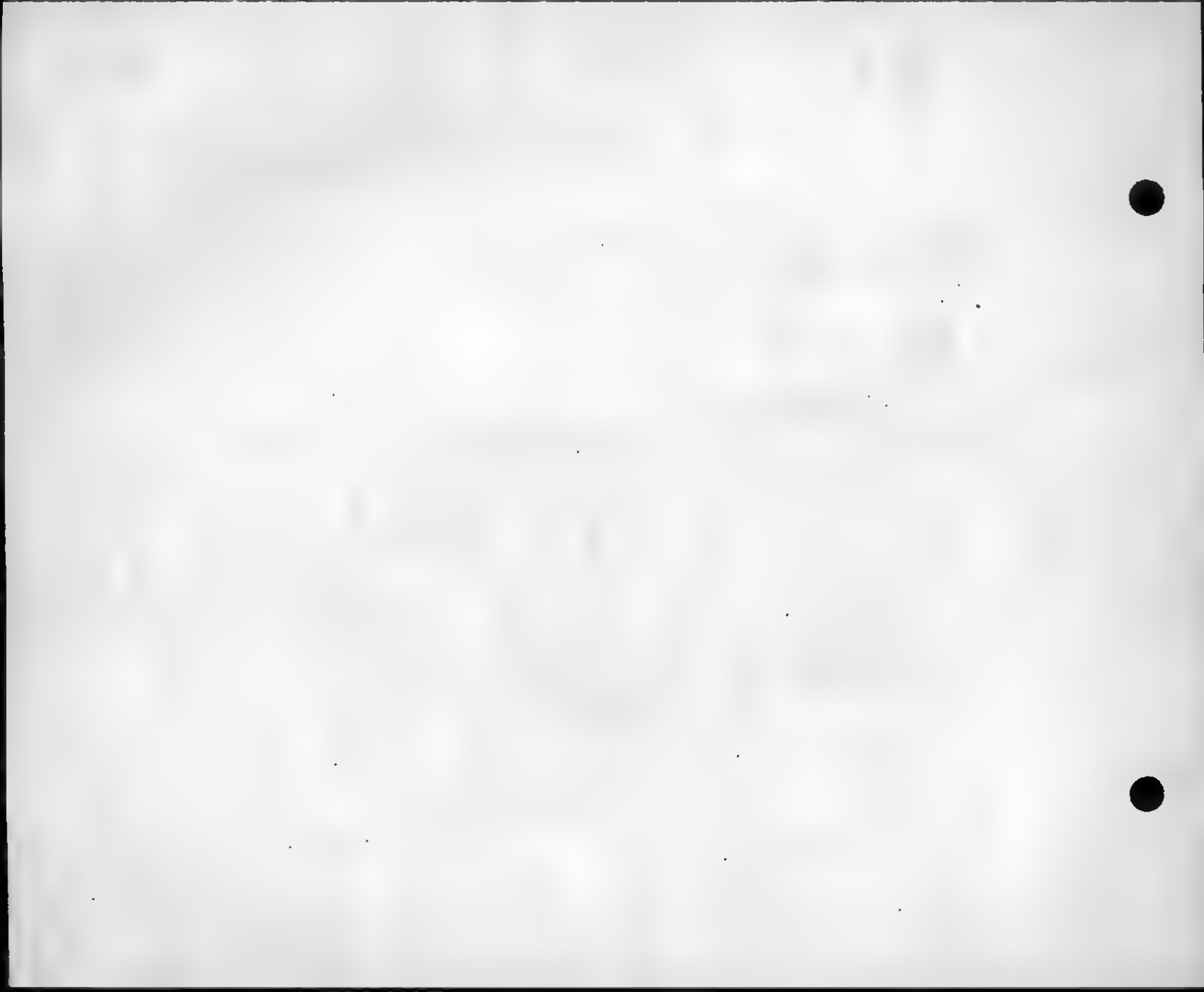


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16810
CERTIFICATE OF DEATH

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Saint Branch Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DC b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 411 E d. STREET ADDRESS 5121-4th St. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Rose L. WICKEN 4. DATE OF DEATH 12-26-1965 | | | | 5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2-18-1886 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No - 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Wm. DICKER (see 2 above) Address | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Cardiovascular collapse DUE TO (b) carcinoma metastasis DUE TO (c) carcinoma of pelvis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mo. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | 21. I certify that I (this hospital) attended the deceased from July 26, 1965 to 12-26, 1965, that I (we) last saw the deceased alive on 12-21-1965, and that death occurred at 9:55 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Arthur G. Willets M.D. 22b. DATE SIGNED 12-26-65 22c. PHYSICIAN'S NAME (Type) ARTHUR G. WILLETS, 22d. ADDRESS 1015 SPRING ST. SPRING MD. | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/28/65 23c. NAME OF CEMETERY OR CREMATORY NATL. MEM. PARK 23d. LOCATION (City, town or county) (State) FALLS CHURCH, VA. | | | |
| 24. FUNERAL DIRECTOR Address 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | 25c. DATE DEC 29 1965 25d. REGISTRAR'S SIGNATURE Charles Judge | | | |



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16811

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

193

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George's | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland | | c. LENGTH OF STAY in 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Andrews Air Force Base Hospital | | d. STREET ADDRESS 7702 Morris Avenue | |
| 3. NAME OF DECEASED (Type or print) Leonard (NONE) Dobrowski | | 4. DATE OF DEATH Month 12 Day 30 Year 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 25 Jan. 1913 |
| 9. AGE (In years lost birthday) 52 yrs | | 10. IF UNDER 1 YEAR Months 12 Days 30 Hours 19 Min 65 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) Nav. Com. Officer | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Dobrowski | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) Yes Ret. 1963 | | 16. SOCIAL SECURITY NO 267-52-3505 | |
| 17. INFORMANT Hilda M. Dobrowski | | Address Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 5810 IMMEDIATE CAUSE (a) Shock DUE TO From Aspiration of vomitus (blood) and Rupture of oesophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO From portal hypertension (c) From cirrhosis of liver. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 m. Day 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 12-31-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1-3-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR W. W. Chambers & Co. 515-11 E.A. & E. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 7 1966 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

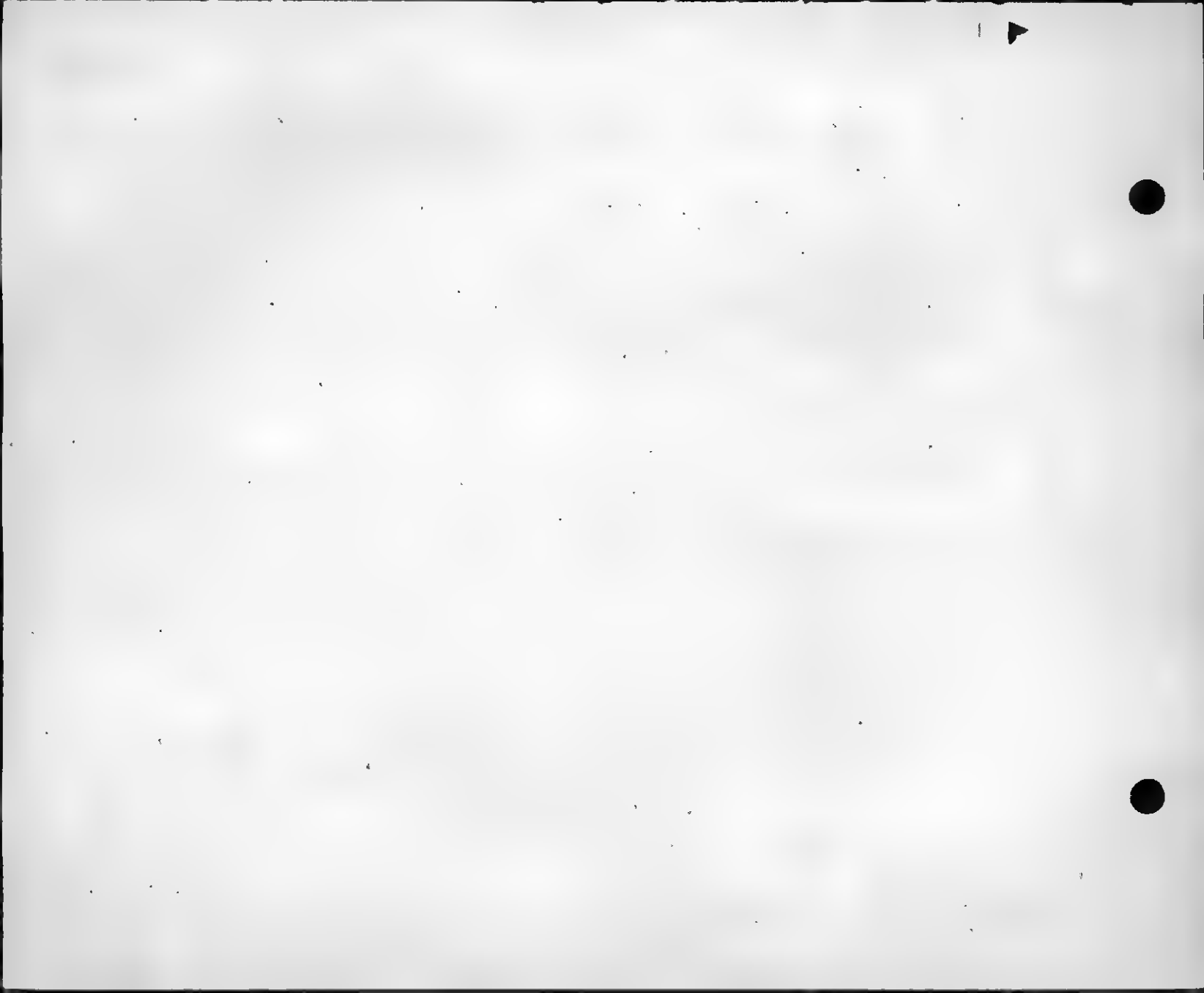
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16812

194

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| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVERDALE c. LENGTH OF STAY IN 1D d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5519 NICHOLSON ST. APT 202 | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVERDALE d. STREET ADDRESS 5519 NICHOLSON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) DANIEL First A Middle DONOHUE Last | | 4. DATE OF DEATH DEC 22 1965 | | 5. SEX MALE | | | |
| 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT 10, 1886 | | | |
| 9. AGE (in years last birthday) 79 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER | | 10b. KIND OF BUSINESS OR INDUSTRY PLUMBING | | | |
| 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME JAMES DONOHUE | | | |
| 14. MOTHER'S MAIDEN NAME MARGARET FEEHAN | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 578-163465 | | | |
| 17. INFORMANT EDITH E. DONOHUE Address SAME AS #2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Vascular 442x DUE TO nephros - sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:00 p.m. 11:00 | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) 15 Sept 65 to 22 Dec 65 | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 15 Sept 1965 to 22 Dec 1965 that (I) (we) last saw the deceased alive on 22 Dec 1965 and that death occurred at 7:10 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Robert C. Haile | | 22b. DATE SIGNED 12/23/65 | | 22c. PHYSICIAN'S NAME (Type) ROBERT C. HAILE | | | |
| 22d. ADDRESS 35 NEW YORK AVE. N.W. D.C. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | |
| 23b. DATE THEREOF 12-27-1965 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md. | | 25a. REC'D BY REGISTRAR DEC 28 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



1 FOR STATE HEALTH DEPT.

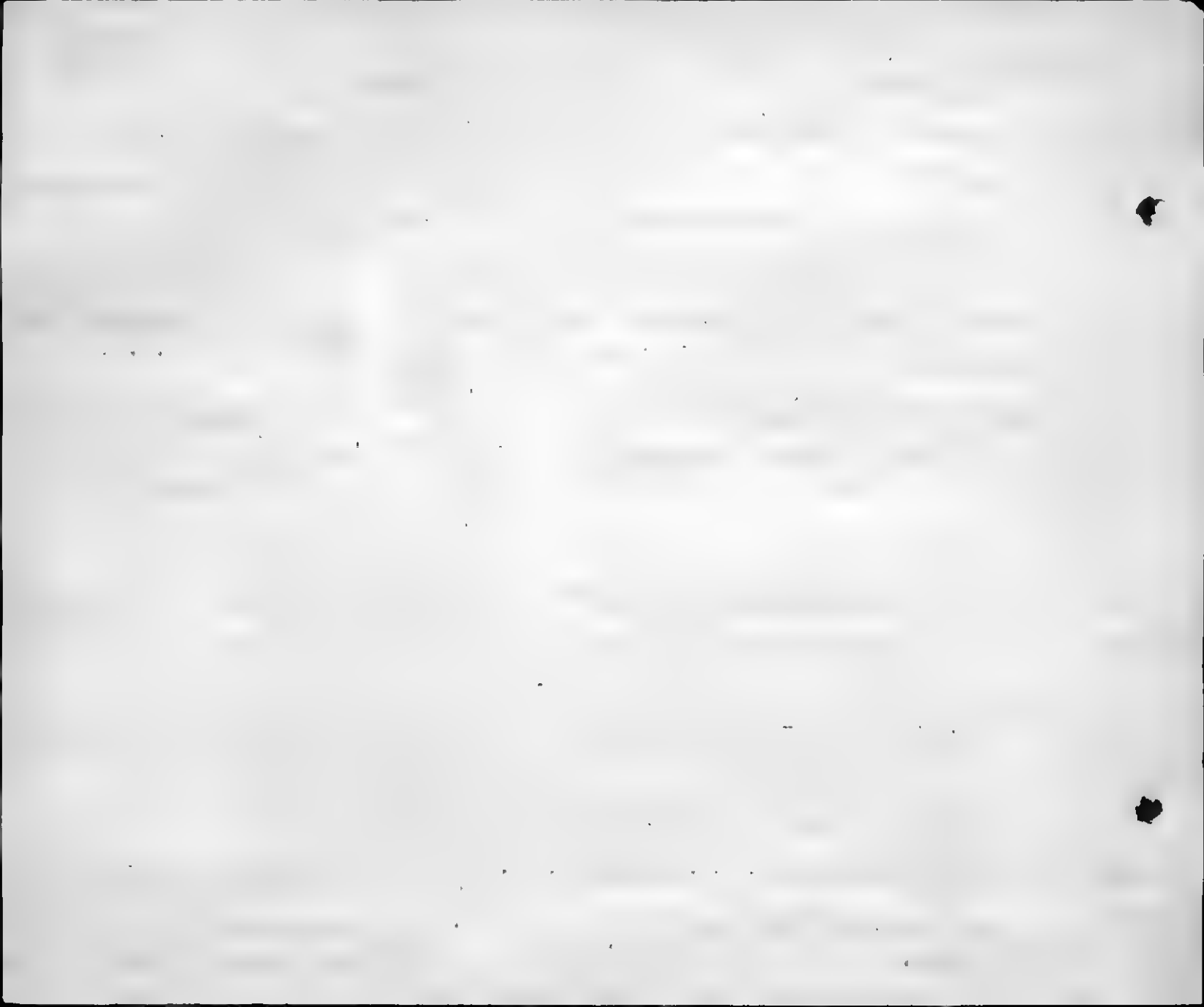
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Pages 5, 6, and 7 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
5M 1/63

| <div> <div>16813</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>95</div> </div> | | | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|------------------|--|--------|------|-------|------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN TB <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> d. STREET ADDRESS <u>3818 Allison Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Maxime L DuCharme</u> | | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1965</u> | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>31 July 1906</u> | | 9. AGE (in years last birthday) <u>59</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Yellow Cab Co.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Glasgow, Scotland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Maxime L. DuCharme</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Stewart</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Evelyn M. DuCharme (above address)</u> Address <u>(Wife)</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head.</u> | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. <u>5:00pm</u> Month, Day, Year <u>12-19-1965</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Same as #2</u> | | (County) | | (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | | | | | M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | 22b. DATE THEREOF <u>12/22/65</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u> | | 22d. LOCATION (City, town, or county) <u>Falls Church, Va.</u> (State) | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Nailey's Funeral Home Inc.</u> | | | | | | ADDRESS <u>Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DEC 28 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16814

196

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | c LENGTH OF STAY IN 1b Y Edmonston | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e STREET ADDRESS 4920 49th Avenue | |
| f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Andro Max Dunaev | | 4 DATE OF DEATH Month Day Year 12 31 19 65 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 1 Oct. 1897 |
| 9 AGE (In years last birthday) 68 yrs | | 10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Driver | | 10b KIND OF BUSINESS OR INDUSTRY Taxi Cab | |
| 11 BIRTHPLACE (State or foreign country) Russia | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME Maxim Dunaev | | 14 MOTHER'S MAIDEN NAME Unknown | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 579 01 6163 | |
| 17 INFORMANT Helen P. Dunaev | | Address Same as #2 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Arteriosclerotic heart disease DUE TO (c) over 10 yrs. | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED 12-31-65 | |
| ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county) | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 1/3/66 | |
| 23c NAME OF CEMETERY OR CREMATORY Geo. Washington Memo. | | 23d LOCATION (City or Town) (County) (State) Hyattsville Maryland | |
| 24 FUNERAL DIRECTOR J. Wm. Lees Sons, Washington, DC | | 25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE | |
| 300 4th St. NE | | DATE JAN 5 1966 | |

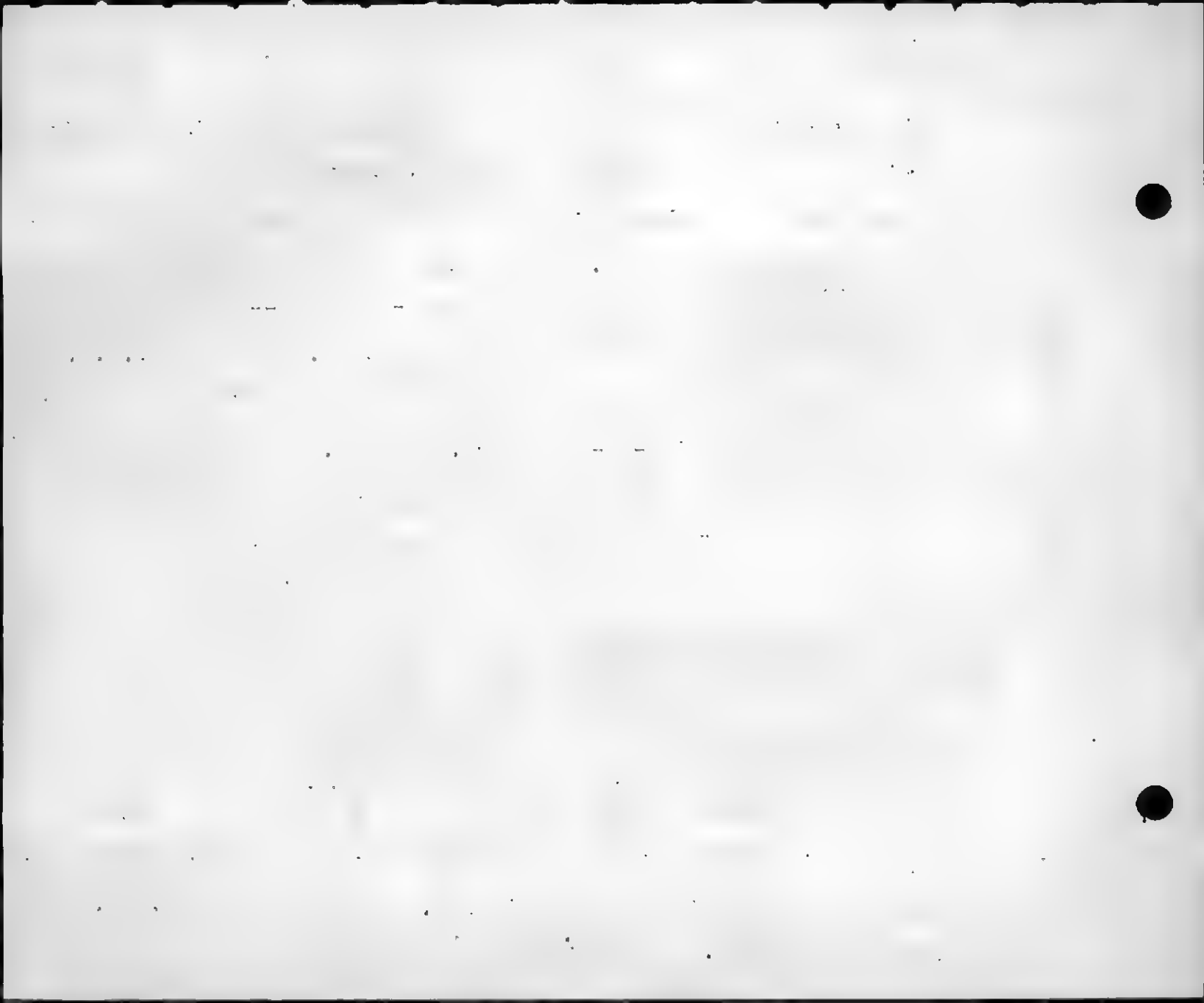


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------|--|
| 16815 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN IL 33 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4308 Russell Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Frank E. Dunklee | | | | | | 4. DATE OF DEATH Month December Day 29 Year 1965 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1899 | | 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sightseeing Guide | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (County & State, or foreign country) Newport, Va. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Frank Dunklee | | | | | | 14. MOTHER'S MAIDEN NAME Nannie Williams | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 578-01-8311 | | 17. INFORMANT Mrs. Sarah L. Dunklee (above address) Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Disease 4201 DUE TO (b) Gen. Arterio Sclerosis Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c) Penetrating Duodenal Ulcer | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrochony | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/26 , 1965, to 12/29 , 1965, that (I) (we) last saw the deceased alive on 12/29 , 1965, and that death occurred at 8:45 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Zouheir Shama | | | | | | 22b. DATE SIGNED 12/29/65 | | 22c. PHYSICIAN'S NAME (Type) Dr. Zouheir Shama | | | |
| 22d. ADDRESS Prince Geo. General Hosp., Cheverly, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 12/31/65 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR Nalley's Home Inc. | | | | | | 25a. REC'D BY REGISTRAR Jan 4 1966 | | 25b. REGISTRAR'S SIGNATURE <i>J. J. J. Judge</i> | | | |



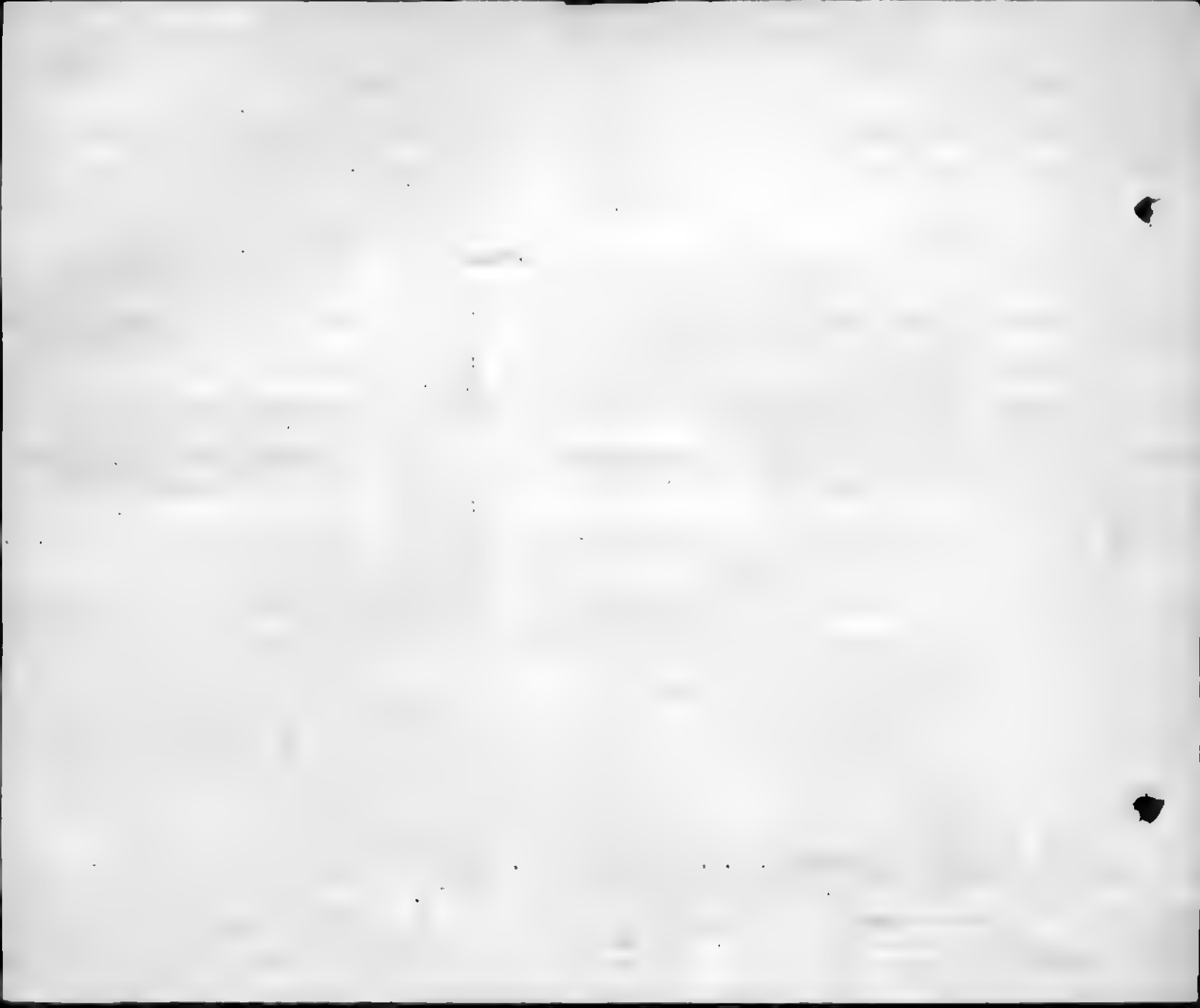
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16816

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 7259 Booker Drive | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clarence William Edmunds | | | | 4. DATE OF DEATH Month Day Year 12 21 1965 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-26-1910 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. - | | | |
| 17. INFORMANT Address Momie Edmunds same as 2D | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio vascular disease | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | DATE SIGNED 12-23-65 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 12-27-65 | | 22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery | | 22d. LOCATION (City, town, or county) Highland Park Md | |
| 23. FUNERAL DIRECTOR H.S. Washington & Son 4925 Beane Ave NE | | | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Charles J. | | | |



FOR STATE
HEALTH DEPT.

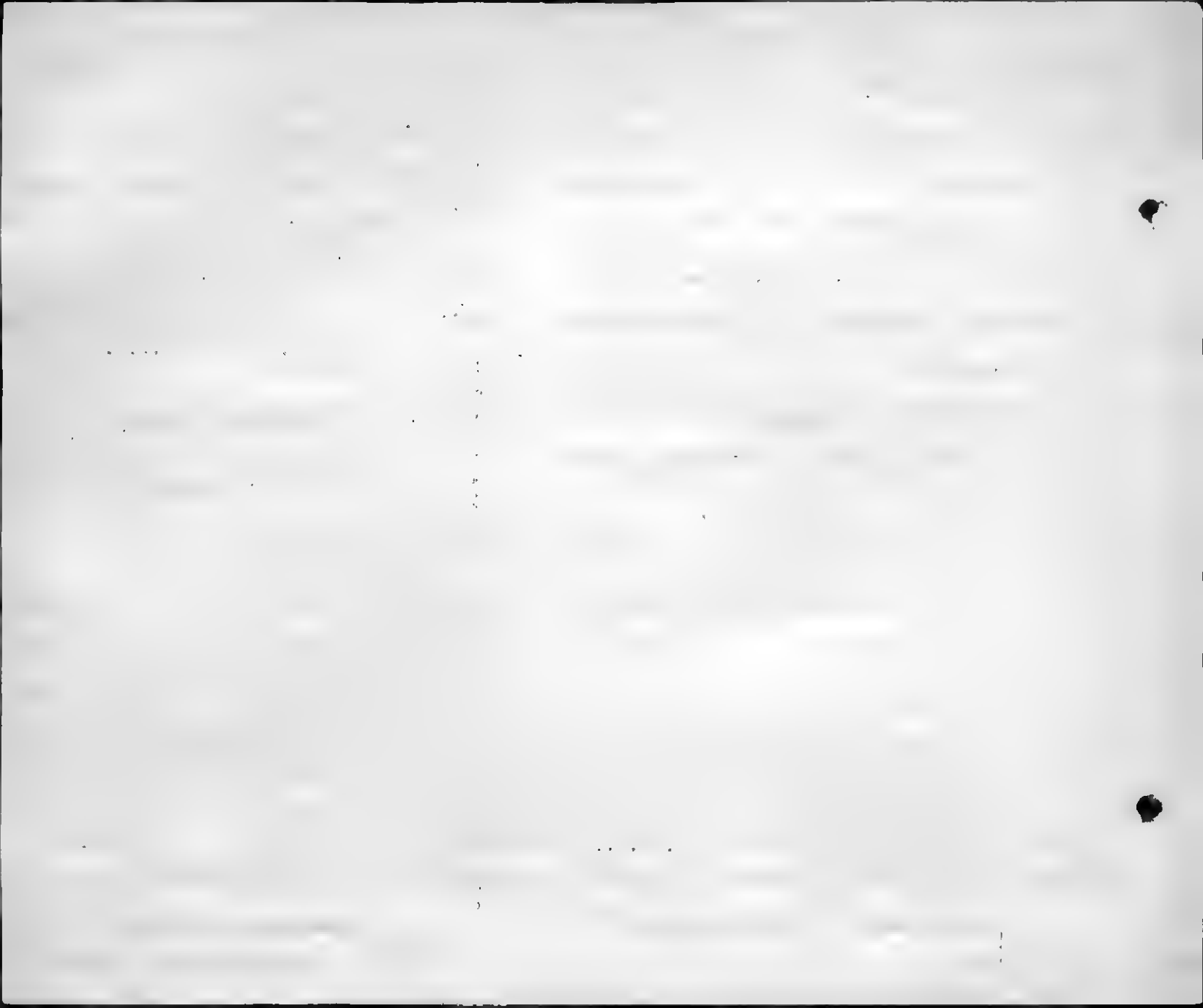
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

16817

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clinton Medical Center | | d. STREET ADDRESS 9111 Susan Lane | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bernard Ernest Emmert | | 4. DATE OF DEATH 12 25 19 65 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 Jan., 1919 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY Cas Light Company | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bernard Emmert | | 14. MOTHER'S MAIDEN NAME Lottie Fowler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Bernard E. Emmert, Jr | | Address 9111 Susan Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| DUE TO (b) Arteriosclerotic heart disease | | | Unknown |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | DATE SIGNED 12-25-65 | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-28-65 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington Virginia | |
| 23. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | 24. REC'D BY REGISTRAR DEC 30 1965 | |
| ADDRESS 308 Suitland Rd Suitland Md | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

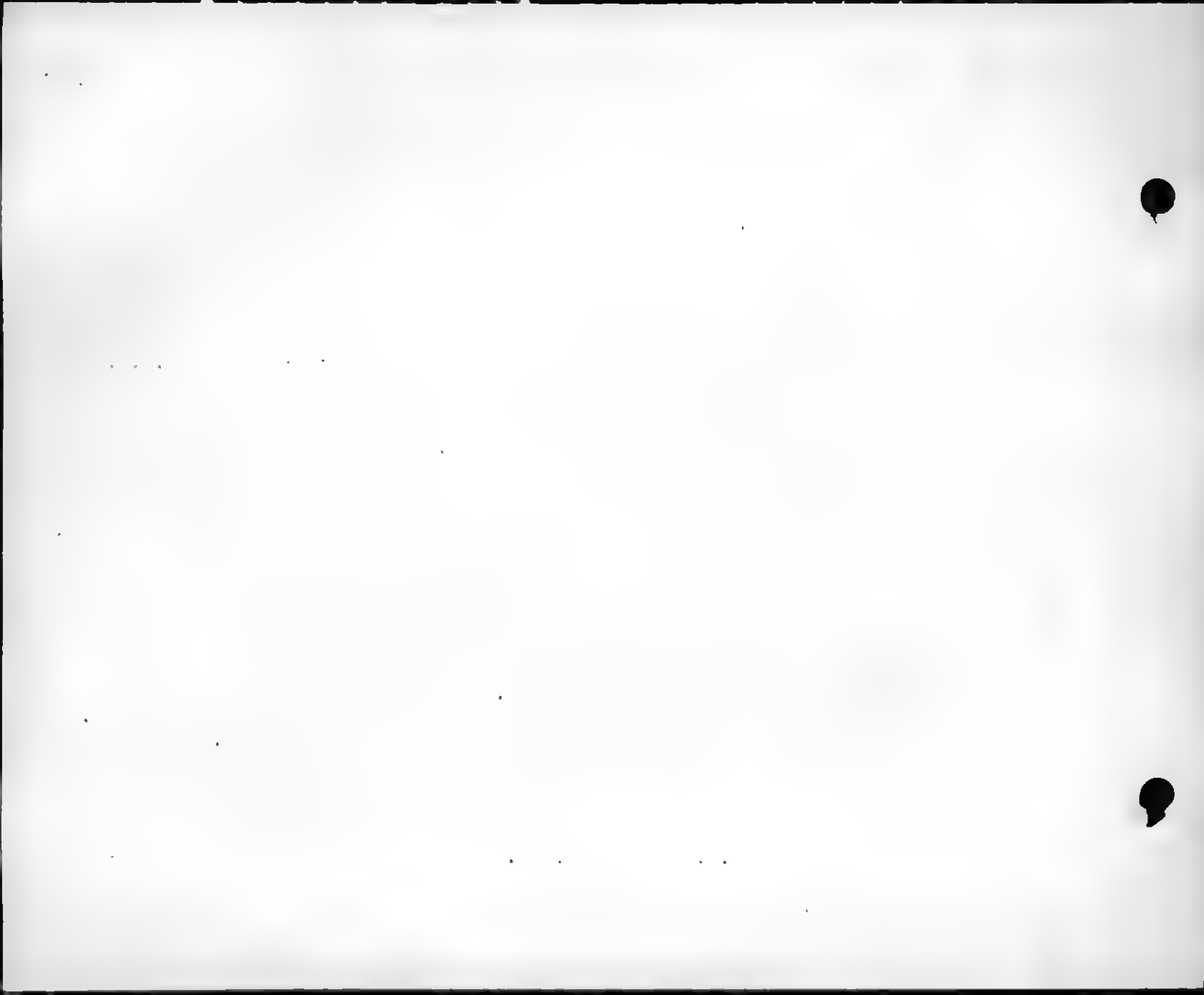
2200

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

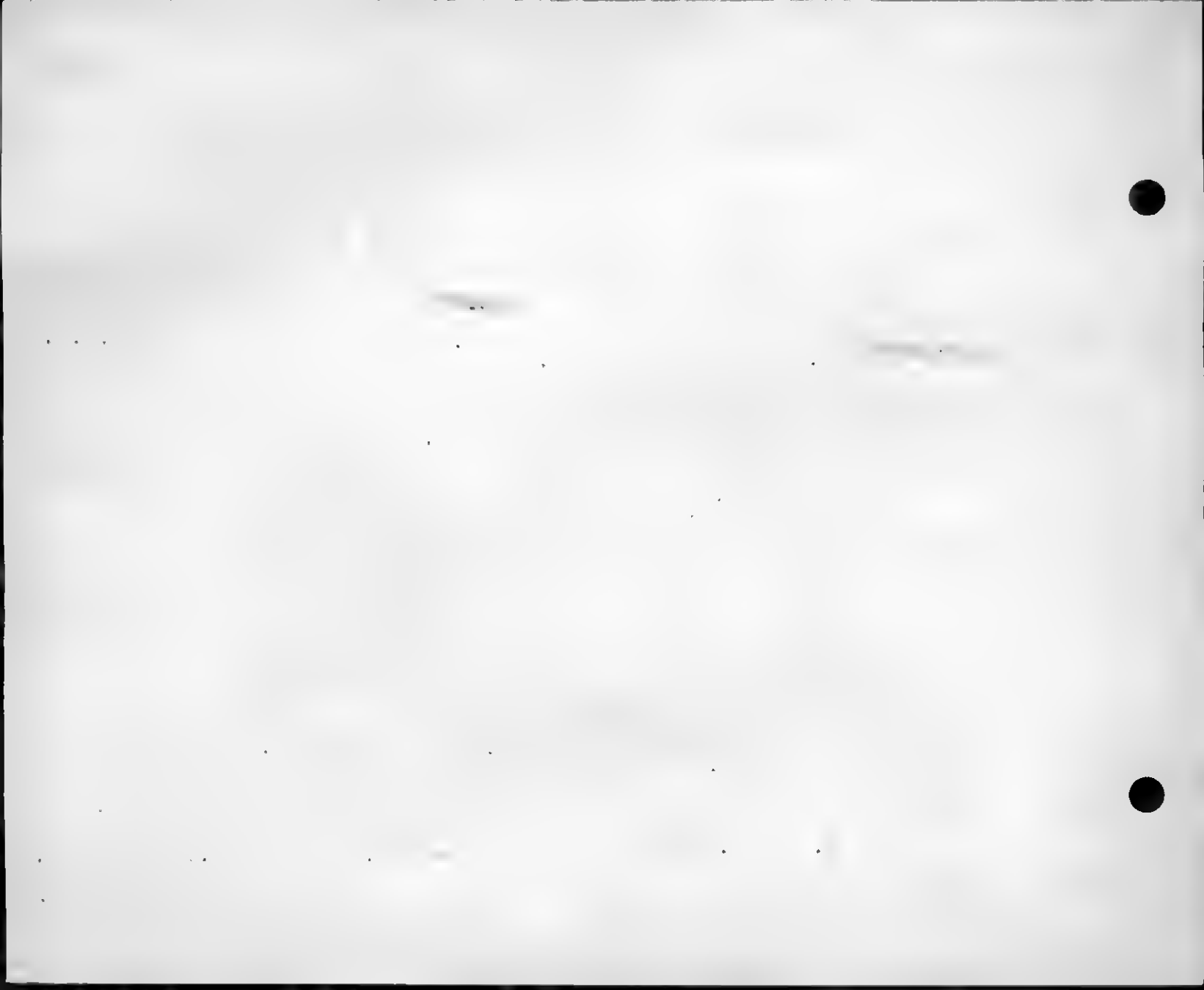
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 609 48th. Avenue | |
| 3. NAME OF DECEASED (Type or print) George Henry Erskine | | 4. DATE OF DEATH 12 29 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 27 May 1942 |
| 9. AGE (in years last birthday) 23 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Mn | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Erskine | | 14. MOTHER'S MAIDEN NAME Viola Simpson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Linda L. Erskine Address 609 48th Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head. | |
| 20c. TIME OF INJURY Month, Day, Year 2:00pm 12-29-1965 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work Bathroom | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 5749 Southern Ave. | | 20f. (City or town) Capitol Heights (County) Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 12-30-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1-3-66 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION (City or Town) Suitland (County) Maryland (State) |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd | | 25a. REC'D BY REGISTRAR DAIAN 4 | 25b. REGISTRAR'S SIGNATURE John Charles Judge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

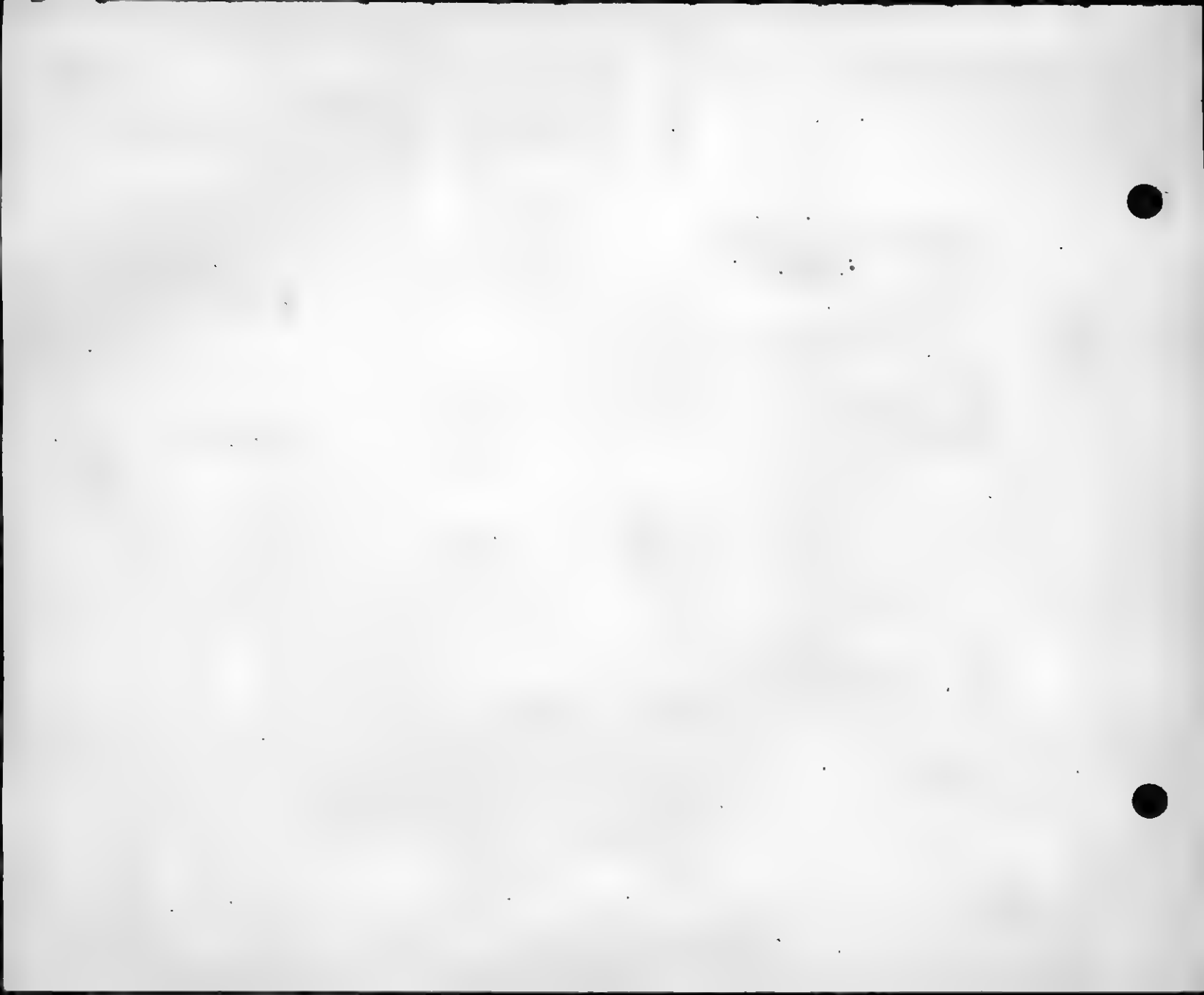
| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4411 Oliver Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle H Last Ewing | | 4. DATE OF DEATH Month December Day 15 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 1, 1889 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. UNDER 1 YEAR Months 6 Days 15 | 11. UNDER 24 HRS. Hours 12 Min. 20 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. Water Proofing Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Water Proofing Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) St. George, West Virginia | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Louis Ewing | | 14. MOTHER'S MAIDEN NAME Mollie Shaeffer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 579-01-5738 | |
| 17. INFORMANT Mary C. Ewing same as #2 | | Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Rt. Lower Lobe DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 10, 19 65 to Dec. 15, 19 65 , that (I) (we) last saw the deceased alive on Dec. 15, 19 65 , and that death occurred at 12:20 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Rosa L. Barlin M.D. | | 22b. DATE SIGNED 12-15-65 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Rosa L. Barlin | | 22d. ADDRESS Prince Geo. General Hosp., Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE THEREOF 12/18/65 | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | 23d. LOCATION (City, town or county) (State) Montgomery County, Md. |
| 24. FUNERAL DIRECTOR J. H. Hines Co. 2901 14th ST. N.W. | | 25. REC'D BY REGISTRAR DEC 20 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16820
CERTIFICATE OF DEATH 1202

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL d. STREET ADDRESS BALTIMORE BLVD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Wilbur F. Faurot | | 4. DATE OF DEATH Month December Day 15 Year 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH SEPT 15 1914 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER | | 10b. KIND OF BUSINESS OR INDUSTRY Meat | 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR: Months 5 Days 5 Hours 5 Min. |
| 11. BIRTHPLACE (County & State, or foreign country) Iowa | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME WILBUR FAUROT | | 14. MOTHER'S MAIDEN NAME MADGE ONSTOTT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 262 03 9444 | |
| 17. INFORMANT MRS MADGE ONSTOTT FAUROT | | Address RT 3 BOX 306 MARIANNA FLA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MENINGITIS 491X DUE TO (b) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS ONE WEEK |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 14 DEC. 1965 to 15 DEC. 1965 , that (I) (we) last saw the deceased alive on 15 DEC. 1965 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE C. J. HOGMANN | | 22b. DATE SIGNED 15 DEC. 65 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. HOGMANN | | 22d. ADDRESS RIVERDALE MD | |
| 23a. BURIAL, CREMATION, REMOVE (Specify) Buried | 23b. DATE THEREOF 12-17-65 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | 23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND |
| 24. FUNERAL DIRECTOR WW Chambers Co. Riverdale Md | | 25a. REC'D BY REGISTRAR DEC 21 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16821

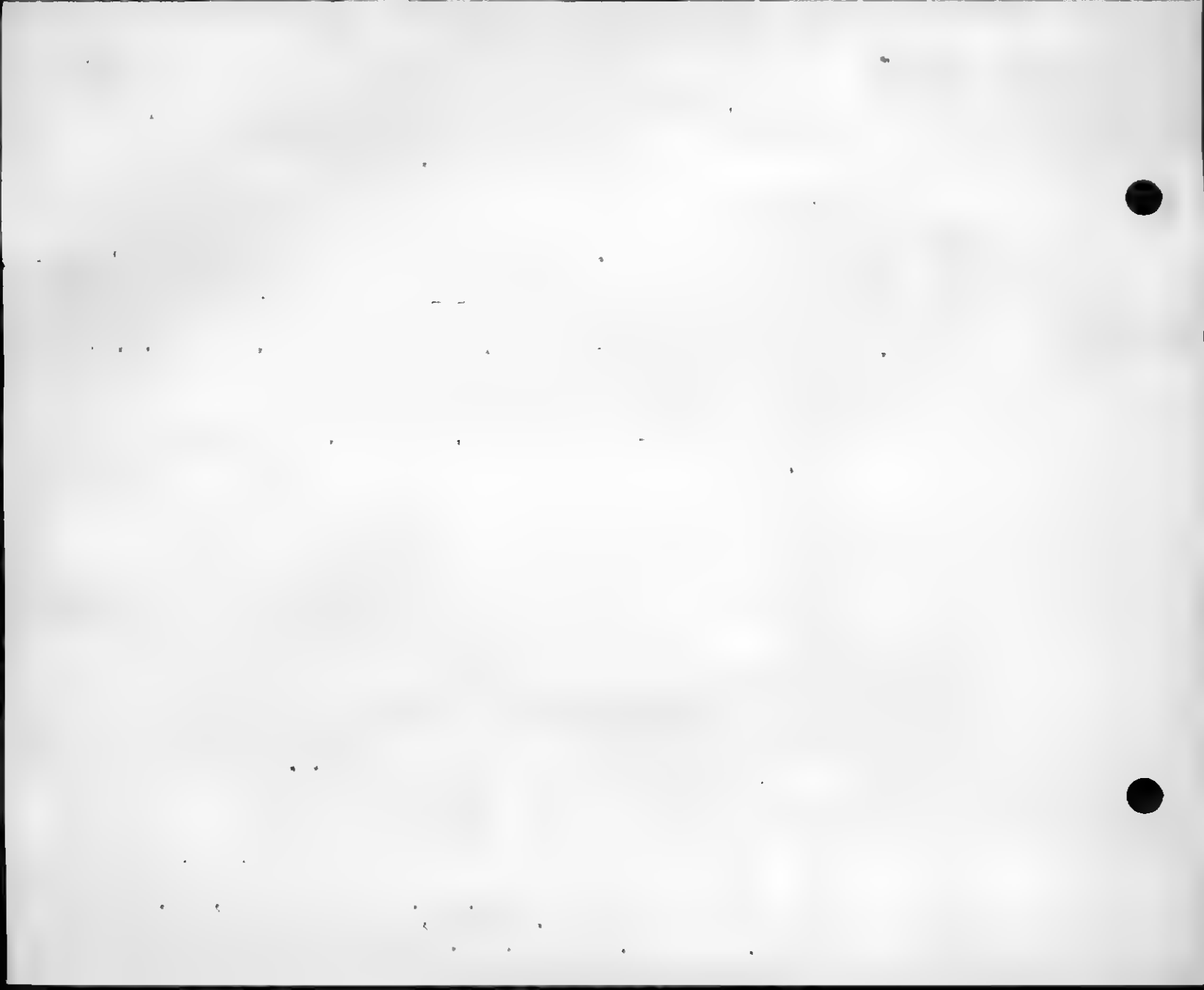
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02013

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Rainier | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 4303 Kaywood Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Vincent Middle T. Last Finn | | 4. DATE OF DEATH Month December Day 15 Year 1965 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-3-1898 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. | | 10b. KIND OF BUSINESS OR INDUSTRY Pepsi-Cola Co. | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John M. Finn | | | | 14. MOTHER'S MAIDEN NAME Vola Stephens | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI | | 16. SOCIAL SECURITY NO. 219-07-8643 | | 17. INFORMANT Mrs. Evelyn K. Finn (above address) (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Myocardial Infarction. (b) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1965 to 12/16/65, that (I) (we) last saw the deceased alive on 11/16/65, and that death occurred at 11:15 p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Leon Levitsky | | | | 22b. DATE SIGNED 12/16/65 | | 22c. PHYSICIAN'S NAME (Type) Dr. Leon Levitsky | |
| 22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/20/65 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | | 25a. ADDRESS Mt. Rainier, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

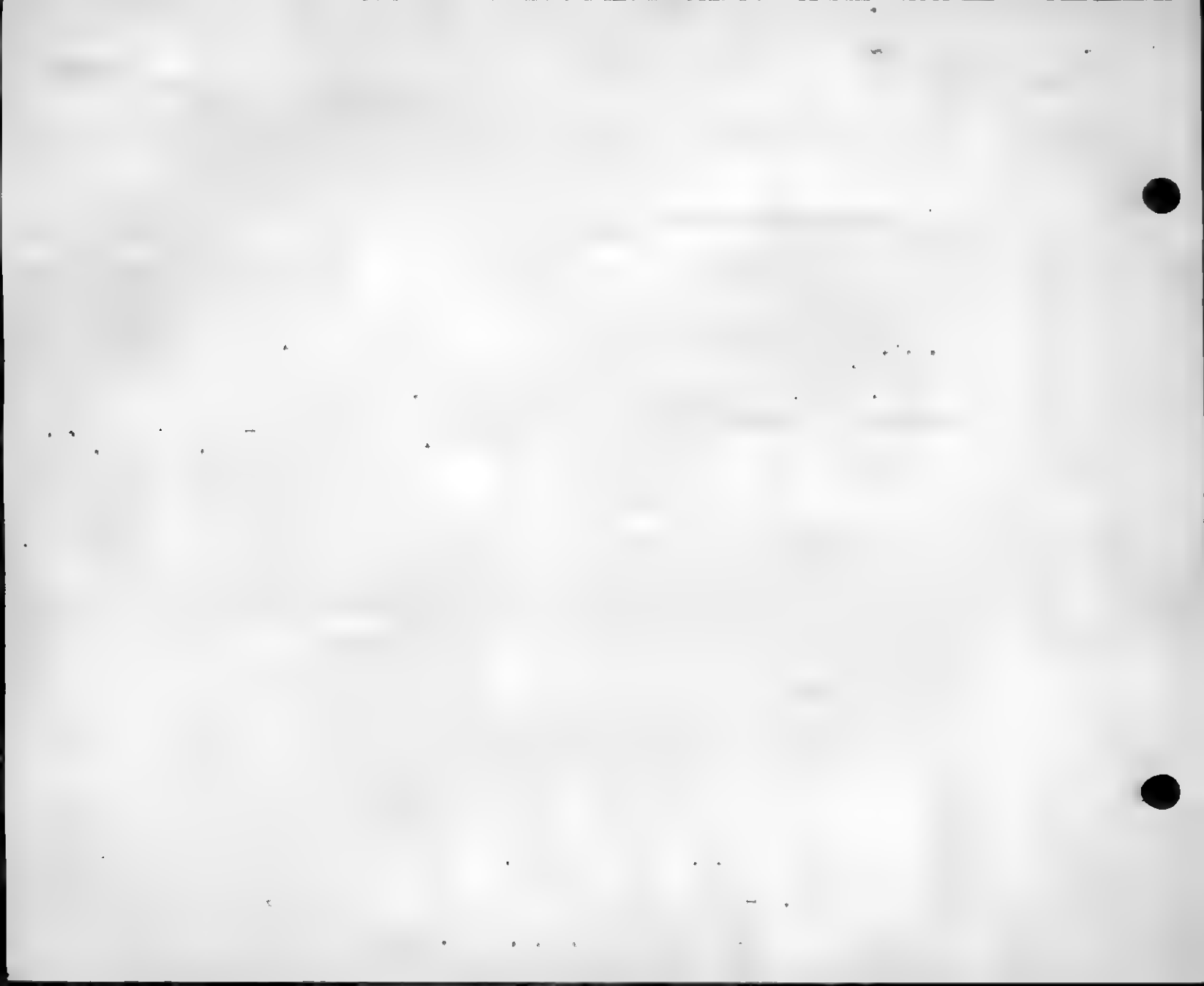
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville | |
| c. LENGTH OF STAY IN 1b DOA | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Marian Teresa Flaherty | | 4. DATE OF DEATH Month 12 Day 5 Year 19 65 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 16 June 1912 |
| 9. AGE (In years last birthday) 53 yrs. | | 10. BIRTHPLACE (State or foreign country) Washington, DC. | |
| 11. CITIZEN OF WHAT COUNTRY? USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas J. Pumphrey | | 14. MOTHER'S MAIDEN NAME Anna M. Sollars | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Bennard J. Flaherty | | Address 10126- Griff Drive S.E. Friendly, Maryland. 20022 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-6-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 9-1965 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Suitland, Maryland | |
| 24. FUNERAL DIRECTOR Simmons Brothers | | ADDRESS 1661- Good Hope Rd. S.E. Wash. DC | |
| 25a. REC'D BY REGISTRAR DEC 7 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



16823

205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Pr George</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr George</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6610 Gude Avenue</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>William</i> First <i>F</i> Middle <i>Thippin</i> Last | | 4. DATE OF DEATH <i>Dec 8</i> Month <i>Dec</i> Day <i>8</i> Year <i>1965</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 28 1889</i> |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Drycleaning</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Va</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Samuel Clark Thippin</i> | | 14. MOTHER'S MAIDEN NAME <i>Jessie Bell Hudson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <i>Mrs. Sandra Lewis</i> Address <i>1301 Furber Ave</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> 4201 DUE TO <i>Chronic Myocarditis with congestive heart failure</i> (b) DUE TO <i>Thrombotic phlebitis left leg</i> (c) <i>12/7/65</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>11/17/65</i> to <i>12/8/65</i> , that (I) (we) last saw the deceased alive on <i>12/7/65</i> , and that death occurred at <i>7:30</i> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Howard T Morse</i> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Print) <i>Howard T Morse</i> | | 22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Dec 14-65</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | | 23d. LOCATION (City, town, or county) (State) <i>Landover Maryland</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i> ADDRESS <i>254 Carroll Ave</i> | | 25a. REC'D BY REGISTRAR <i>DEC 13 1965</i> | |
| | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | |

Bf



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16824

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

206

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7608 Marlboro Pike | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS Forestville | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Kathryn Marie Folk | | 4. DATE OF DEATH 12/7/1965 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5 Nov. 1963 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 2 yrs. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard James Folk | | 14. MOTHER'S MAIDEN NAME Eleanor Florence Walsh | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Richard J. Folk | | Address 7708 Marlboro Pike | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns 40% of body surface DUE TO (b) And intoxication of Carbon dioxide and carbon monoxide DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Trapped in burning house | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12-7-1965 10:50 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Same as #2 | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-8-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-10-65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington Virginia | |
| 24. FUNERAL DIRECTOR Thelma Funeral Home 4308 Suitland Rd Suitland Maryland | | 25a. REC'D BY REGISTRAR DEC 13 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



1
FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16825

1207

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN ID DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7608 Marlboro Pike d. STREET ADDRESS Forestville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Michael Andrew Folk | | 4. DATE OF DEATH Month Day Year 12 7 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 July 1957 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday) 8 yrs. IF UNDER 1 YEAR: Months Days Hours Mln. IF UNDER 24 HRS. |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard James Folk | | 14. MOTHER'S MAIDEN NAME Eleanor Florence Walsh | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Richard J. Folk | | Address 7708 Marlboro Pike | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns 35% of body surface 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) and Intoxication of carbon dioxide and carbon monoxide DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in burning house. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:50 p.m. 12-7- 1965 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Same as #2 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED 12-8-65 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-10-65 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | 23d. LOCATION (City, town or county) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland | | 25a. REC'D BY REGISTRAR DEC 13 1965 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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35DD 4-64

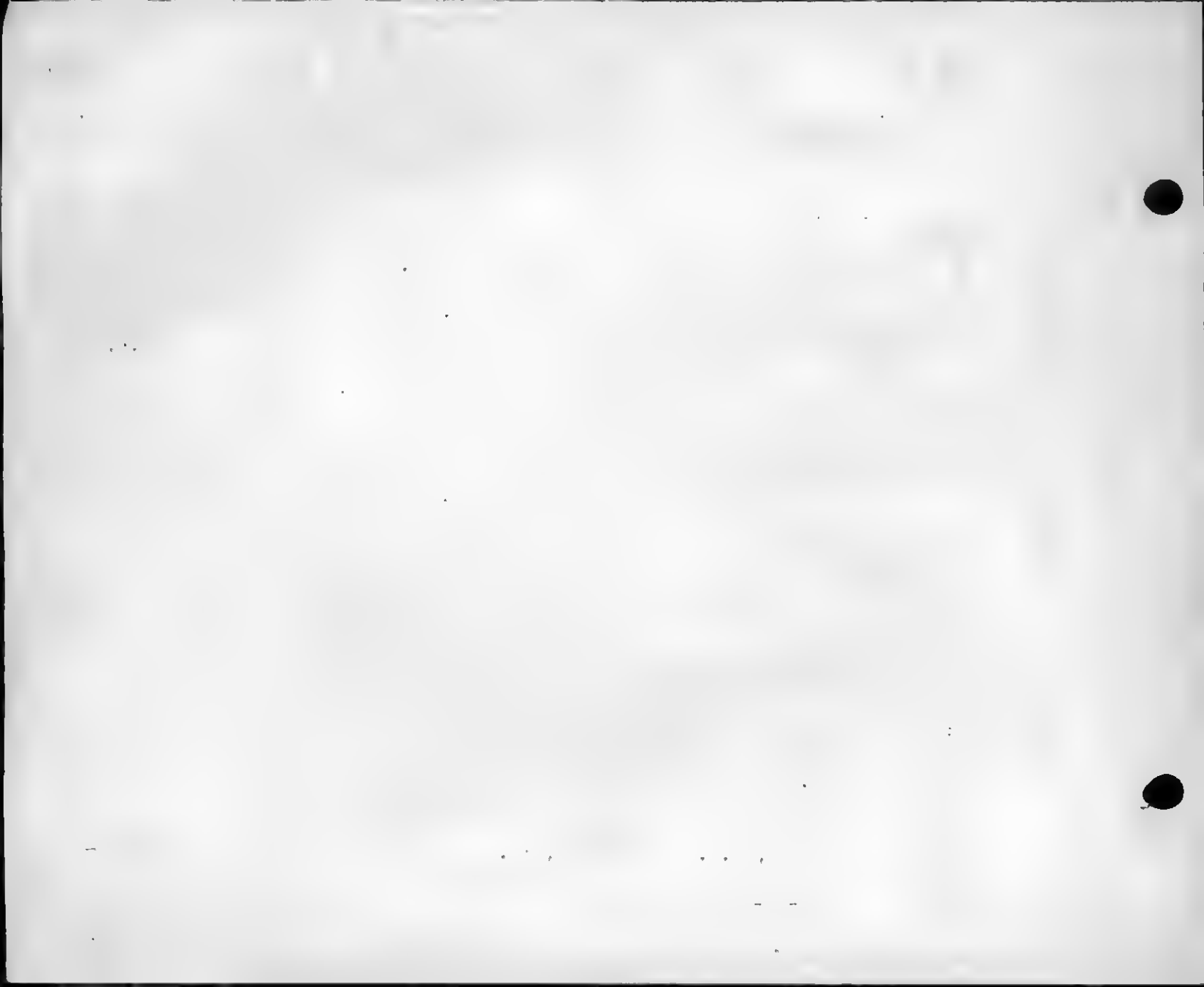
16826

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1208

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Forestville d. STREET ADDRESS 7608 Marlboro Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Richard James Folk Jr. | | 4. DATE OF DEATH Month Day Year 12 7 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5 Oct. 1961 |
| 9. AGE (in years last birthday) 4 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard James Folk | | 14. MOTHER'S MAIDEN NAME Eleanor Florence Walsh | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Richard J. Folk | | Address 7708 Marlboro Pike | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication of carbon dioxide and carbon monoxide 9160 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Trapped in burning house | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10:50 p.m. 12-7-19 65 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Same as #2 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D. | | 22. DATE SIGNED 12-8-65 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-10-65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington Virginia | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 430° Suitland Rd Suitland Maryland | | 25a. REC'D BY REGISTRAR DEC 13 1965 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16827

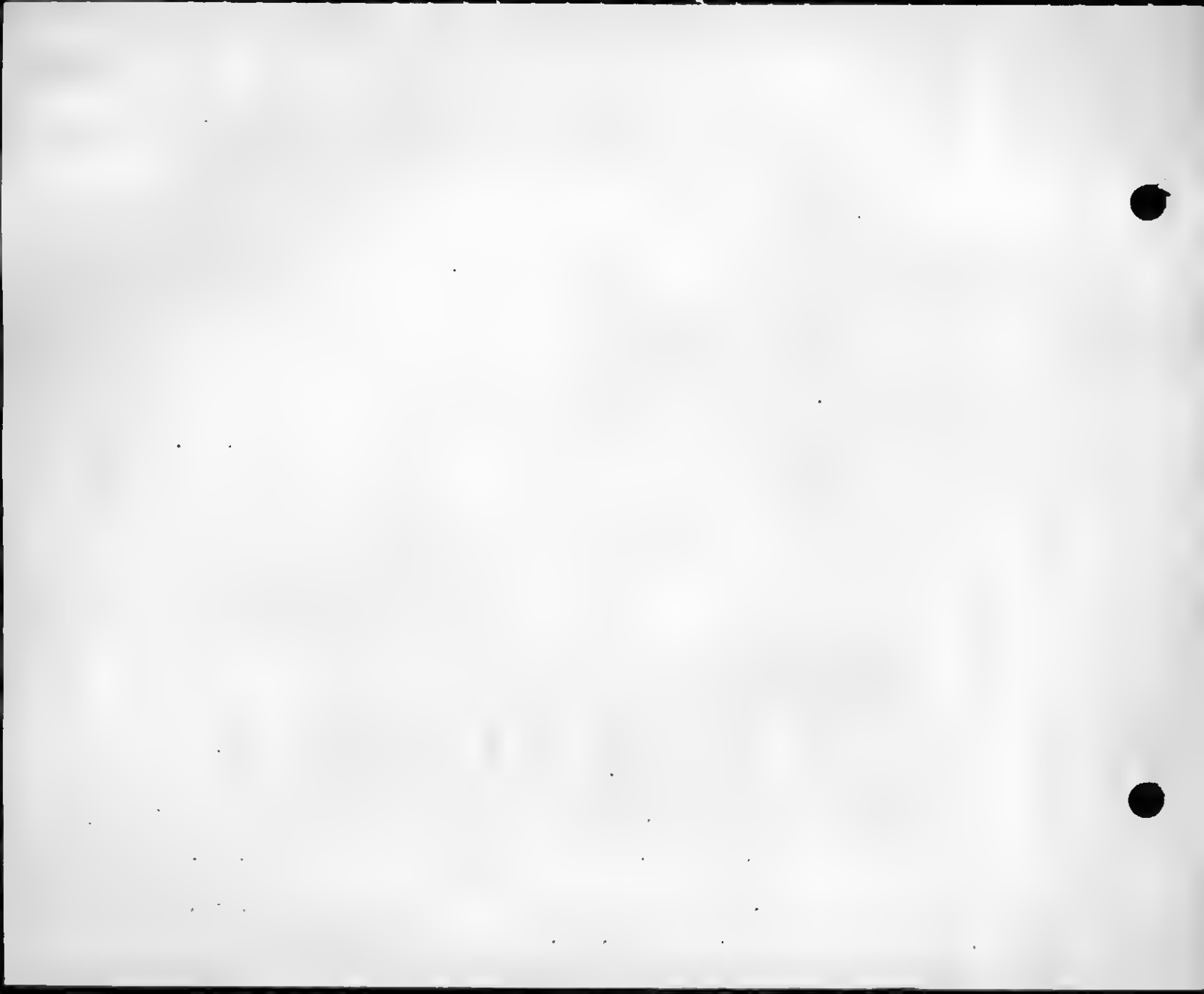
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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| | | | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Takoma Park d. STREET ADDRESS 1212 Myrtle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Bertha First Bertha Middle V Last Fowler | | | 4. DATE OF DEATH Month December Day 17 Year 1965 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH April 18, 1882 | | 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 17 Hours 12 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (County & State, or foreign country) Prince Georges Md. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME George G. Stewart | | | | | |
| 14. MOTHER'S MAIDEN NAME Emma Jane Binnix | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | | |
| 16. SOCIAL SECURITY NO. 577 017 423A | | 17. INFORMANT Ethel Fowler Tokoma Park, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO (b) Pulmonary Edema DUE TO (c) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 65 , to 12/17 , 19 65 , that (I) (we) last saw the deceased alive on 12/17 , 19 65 , and that death occurred at 12 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Leon R. Levitsky | | 22b. DATE SIGNED 12/17/65 | | 22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky | | | |
| 22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md. | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 20, 1965 | | 23c. NAME OF CEMETERY OR CREMATOR Cedar Hill Cemetery | | | |
| 23d. LOCATION (City, town or county) Suitland, Md. | | 23e. (State) | | | | | |
| 24. FUNERAL DIRECTOR F. G. Sch's Sons | | 24b. ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 22 1965 | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | 25c. DATE | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

| <div> <div>16823</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div> | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>4</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> d. STREET ADDRESS <u>3211 Varnum Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret Rattray Scot Fralic</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-21-1894</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months <u>12</u> Days <u>22</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>65</u> | | | | | | 4. DATE OF DEATH <u>12-23-65</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK, RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u> 11. BIRTHPLACE (State or foreign country) <u>Scotland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S</u> | | | | | |
| 13. FATHER'S NAME <u>ARTHUR SCOTT</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>214 207248</u> 17. INFORMANT <u>W. BURCHER BROWN</u> Address <u>SAME AS #2</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>MARY SMITH STEPHEN</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>9000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Skull fracture</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps at home</u> | | | | | | 20c. TIME OF INJURY Month, Day, Year <u>12-18-1965</u> Hour a.m. <u>5:45</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Same as #2</u> (County) <u>Prince George's</u> (State) <u>Md.</u> | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-23-65</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 22b. DATE THEREOF <u>12-24-65</u> 22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u> 22d. LOCATION (City, town, or county) <u>BLADENSBURG, MARYLAND</u> | | | | | | 23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u> 24a. REC'D BY REGISTRAR <u>DEC 28 1965</u> 24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | |

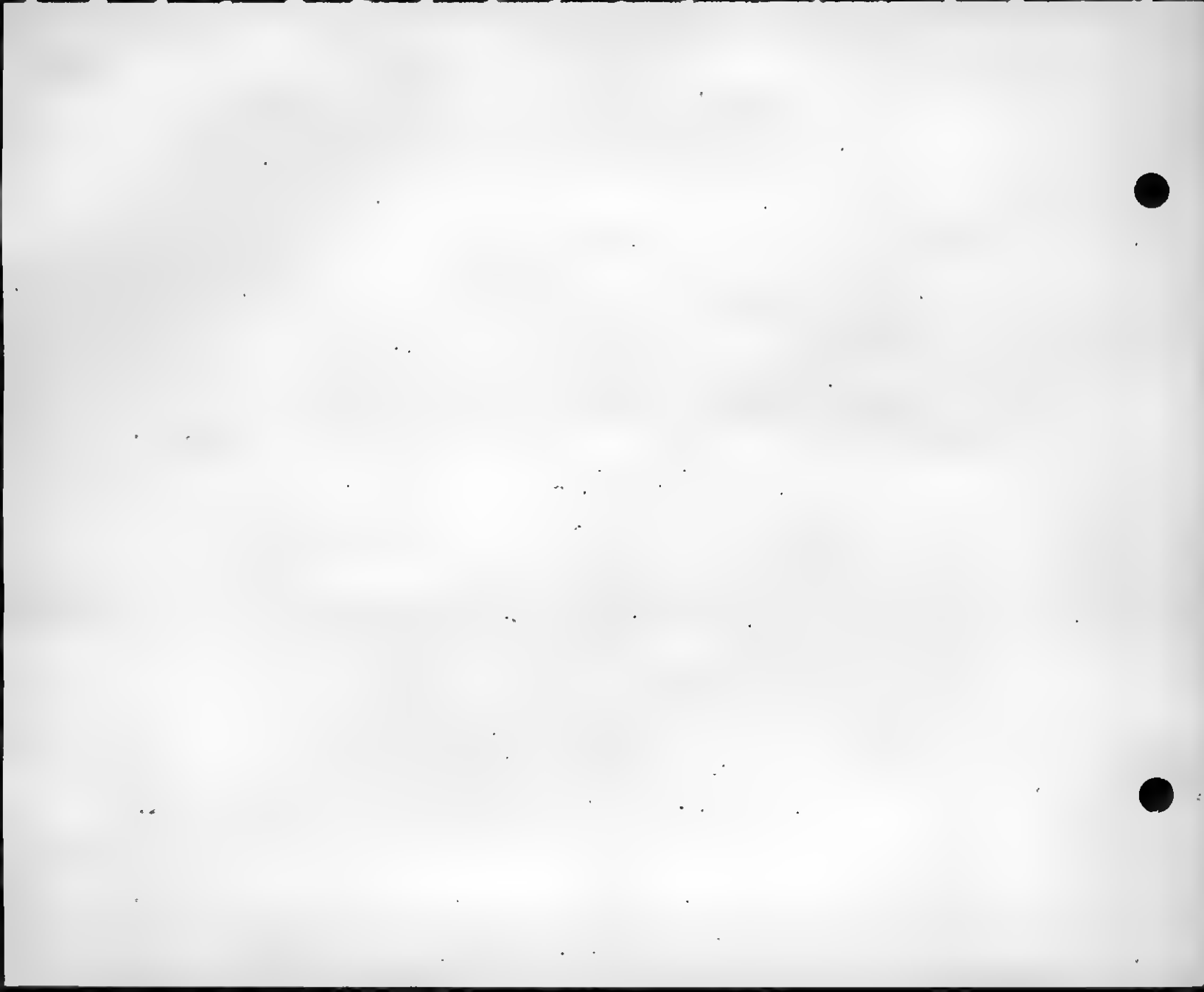


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 16823 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham Md c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Magnolia Nursing home | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Lewisdale, Md. d. STREET ADDRESS 2101 Amherst Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary M. France | | | 4. DATE OF DEATH Month Day Year Dec 24, 19 65 | | | 5. SEX female | | | 6. COLOR OR RACE white | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH | | | 9. AGE (in years last birthday) 82 yrs. | | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY own home at work | | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME John Watson | | | | | | 14. MOTHER'S MAIDEN NAME Matilda Clark | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | 17. INFORMANT Address Edward Sparrough Lewisdale, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> DUE TO (b) <i>Hypertensive</i> DUE TO (c) <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malignant melanoma</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>30 yrs</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 1950, to <i>12/24</i> , 1965, that (I) (we) last saw the deceased alive on <i>12/24</i> , 1965, and that death occurred at <i>HP</i> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Julius Kuffman</i> | | | | | | 22b. DATE SIGNED <i>12/24/65</i> | | | 22c. PHYSICIAN'S NAME (Type) <i>JULIUS KUFFMAN, M.D.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF Dec 28, 1965 | | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | |
| 24. FUNERAL DIRECTOR <i>F. Basch's Sons, 16345ville, Md</i> | | | | | | 23d. LOCATION (City, town or county) Washington D C. | | | 25a. REC'D BY REGISTRAR <i>DEC 29 1965</i> | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN LD MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S GEN HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YGLENDALE d. STREET ADDRESS BOX 33 TELEGRAPH e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) GUSTAV | | First GUSTAV | | Middle FRONCK | | Last FRONCK | | 4. DATE OF DEATH DEC 31 1965 | | Month DEC Day 31 Year 1965 | |
| 5. SEX MALE | | 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 6, 1901 | | 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Mln. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY MEAT MARKET | | 11. BIRTHPLACE (County & State, or foreign country) GERMANY | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME JOHN FRONCK | | | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 577-12-5589 | | 17. INFORMANT ENA P. FRONCK | | | Address SAME AS #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes several years several years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 12/31/65 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1964 , to 12/31, 1965 , that (I) (we) last saw the deceased alive on 12/31 1965 , and that death occurred at 12:30 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James Kurtz | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1-1-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) H. James Kurtz | | | | | | 22d. ADDRESS RFD Glenndale Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1-4-1966 | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | | | | 23d. LOCATION (City, town or county) (State) BLADENSBURG MARYLAND | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 7 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

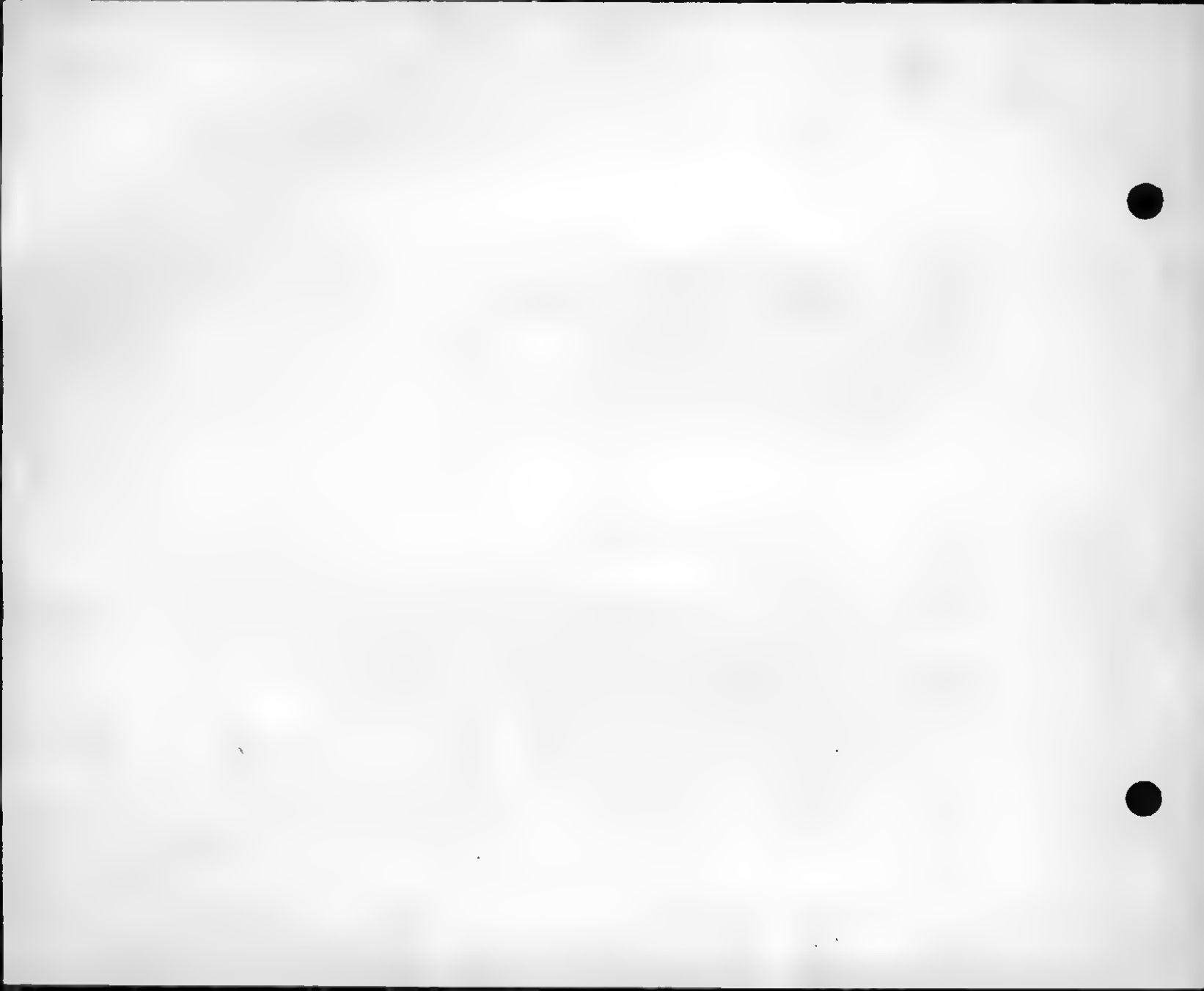
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16831

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1213

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> | | c. LENGTH OF STAY IN 1b <u>years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9100 Adelphi Road</u> | | | | d. STREET ADDRESS <u>9100 Adelphi Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MAGDALENA</u> Middle <u>G</u> Last <u>GARDEN</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1965</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 22 1884</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Frank Dyer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Gullett</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>579 281112</u> | | 17. INFORMANT <u>Mrs. Rosemary E. Royz</u> (Name and address) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 44. X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic & hypertensive cardiovascular disease</u> DUE TO (c) <u>Obesity</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Obesity</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>1957</u> , 19 <u> </u> , to <u>12-9</u> , 19 <u>65</u> , that (2) (we) last saw the deceased alive on <u>12-8</u> , 19 <u>65</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>R.D. Bauer MD</u> | | | | 22b. DATE SIGNED <u>12-10-65</u> | | 22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, MD</u> | |
| 22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi, Md.</u> | | 22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>Dec. 13, 1965</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington, DC</u> | |
| 24. FUNERAL DIRECTOR <u>John Walters</u> | | 24b. ADDRESS <u>254 CORRAL RD. N.W.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 13 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> | |



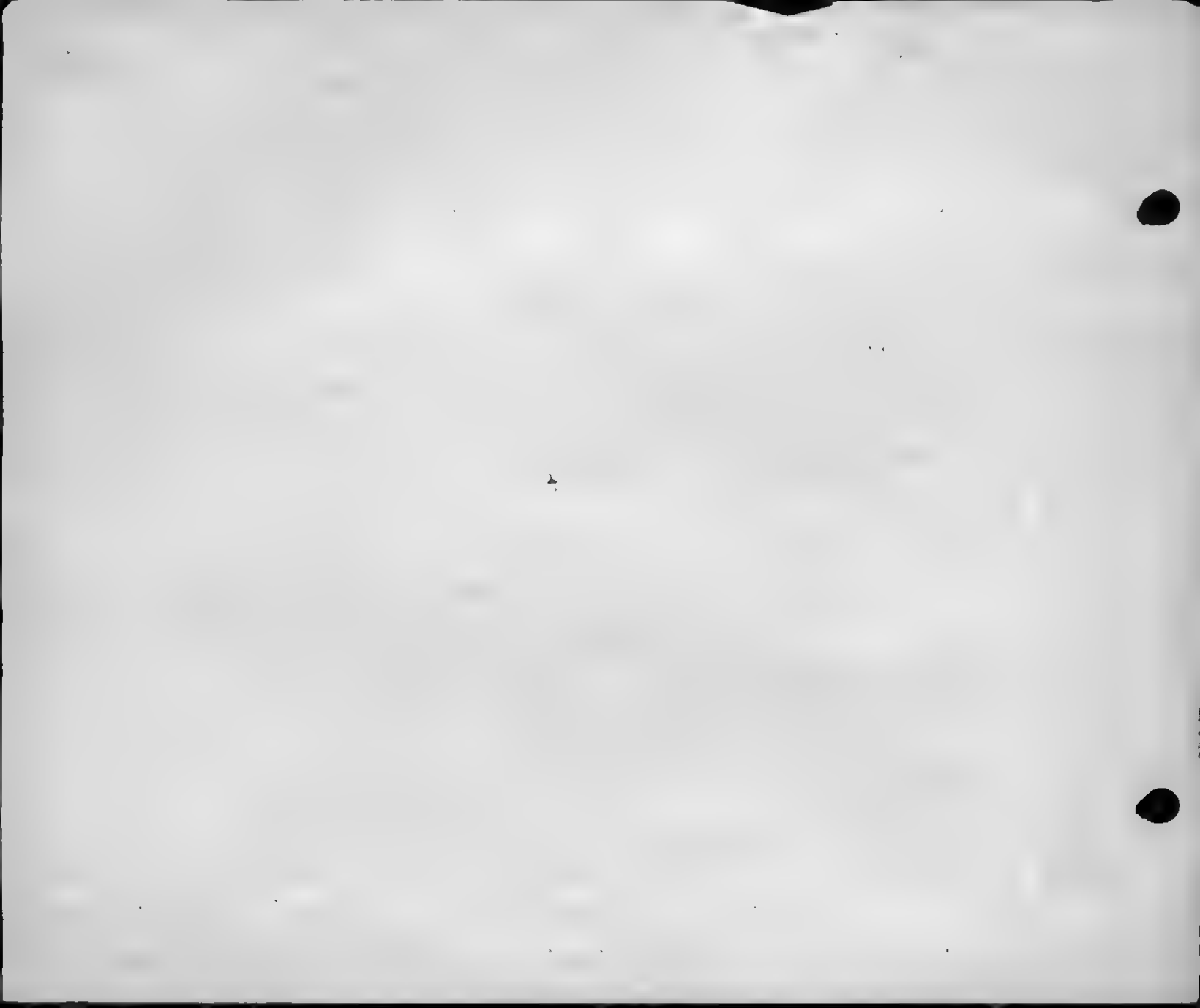
OK by Dr J. Kehoe
DEPT MED. EXAMINER

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VR A15 (4)
20M 5-63

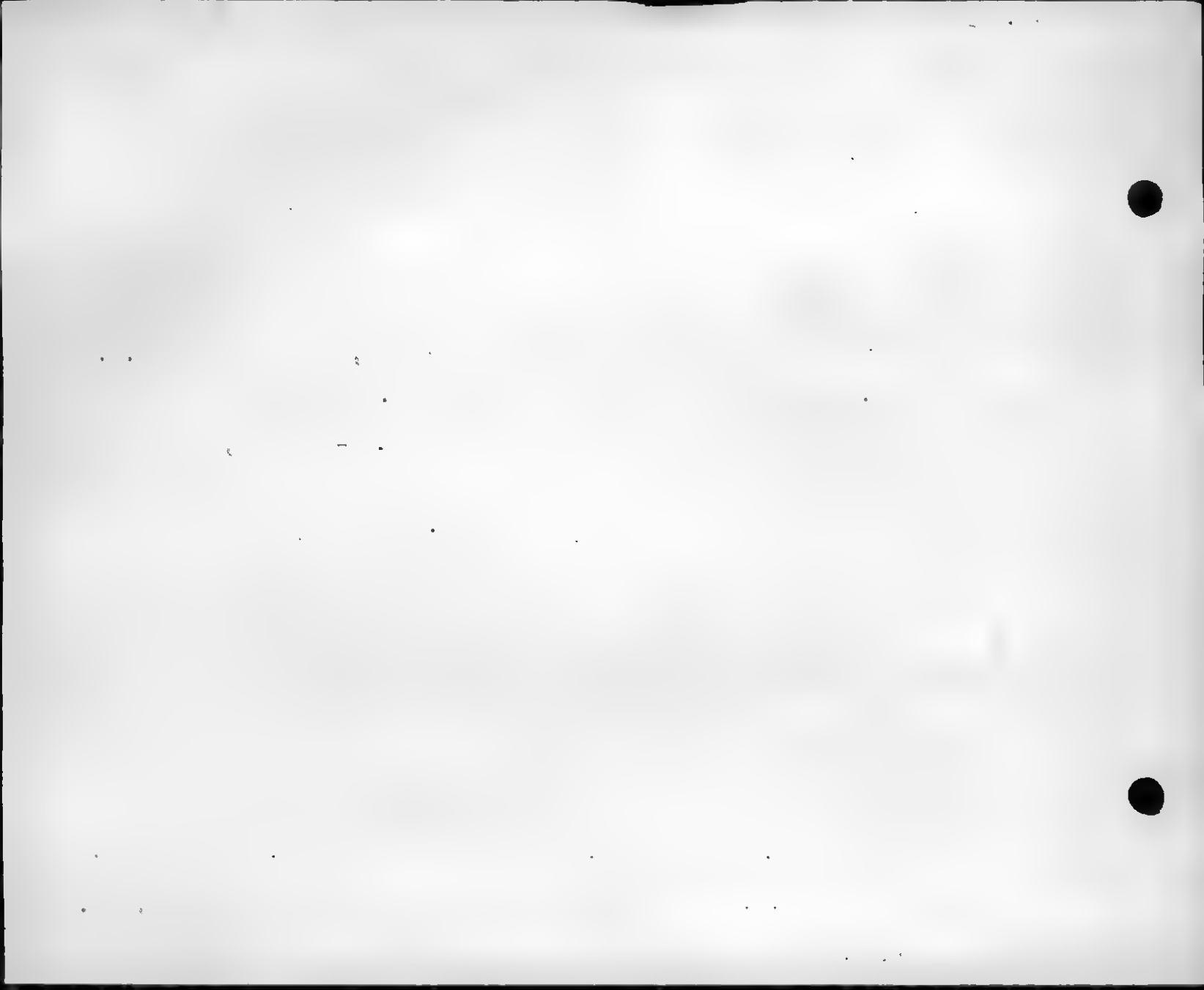
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| Item #9 Film #1312 7/5/66 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u> | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u> | | | | | | c. LENGTH OF STAY IN 1b <u>30+ yrs</u> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3710 PARKWOOD ST</u> | | | | | | d. STREET ADDRESS <u>3710 PARKWOOD ST.</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>C</u> Last <u>GASKILL</u> | | | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1965</u> | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan 17, 1883</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - PO.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PO.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MINNESOTA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>George W. Gaskill</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Reina</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | | 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Edna M Gaskill Cottage City, Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>3 mos</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>61</u> to <u>Dec 28</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 19</u> 19 <u>65</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Norman D. Omeau</u> M.D. | | | | | | 22b. DATE <u>12/28/65</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>NORMAN D. OMEAU</u> | | | | | | 22d. ADDRESS <u>3503 PENNY ST MI ANNAPOLIS</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>Dec 31, 1965</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Jasch's Sons</u> | | | | | | ADDRESS <u>Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>JAN 3 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|-------------------------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 16833 Item #1 Film #G372 12/28/65 pc | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lanham | | | | d. STREET ADDRESS 19103 Wallace Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Earl | | Middle | | Last Gatewood | | 4. DATE OF DEATH | | Month December Day 4 Year 1965 | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/11/02 | | 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Webster College | | 11. BIRTHPLACE (County & State, or foreign country) Madison, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Louis O. Gatewood | | | | | | 14. MOTHER'S MAIDEN NAME Mary E. Tollover | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Edna Gatewood - 9103 Wallace Road Lanham, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic and shock reaction</u> DUE TO (b) <u>Necrosis of large and small</u> DUE TO (c) <u>mesenteric thrombosis</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> , 19 <u>65</u> , to <u>12-4</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-4</u> , 19 <u>65</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Amir S. Banisadr</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-4-65</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) Amir S. Banisadr, M.D. | | | | | | 22d. ADDRESS 6323 Landover Rd., Cheverly, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 23b. DATE THEREOF 12-7-65 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Prince Georges, Md. | | | | 23d. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR <u>John T. Rhinehart</u> | | | | | | ADDRESS <u>3015 12th St. N.E.</u> | | DEC. BY REGISTRAR <u>DEC 9 1965</u> | | 25. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1000000

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE VIRGINIA | | b. COUNTY ARLINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB | | c. LENGTH OF STAY IN 1b 1 Month | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON | | d. STREET ADDRESS 840 S DICKERSON ST | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) OUIDA | | First KNIGHT | | Middle GEESEY | | Last DECEMBER 19 1965 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAUC | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 21 APRIL 21 | |
| 9. AGE (in years last birthday) 44 yrs. | | 10. UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (County & State, or foreign country) GEORGIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | | |
| 13. FATHER'S NAME CARL L KNIGHT | | | | 14. MOTHER'S MAIDEN NAME JULIA BROOKS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 248-24-9143 | | 17. INFORMANT HUSBAND | | Address SAME AS ITEM #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown Cause DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver with ascites and Gastrointestinal Hemorrhage | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 18, 1965 , to Dec 19, 1965 , that (I) (we) last saw the deceased alive on Dec 19, 1965 , and that death occurred at 11:00 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE David S. Miller, Capt USAF MC | | | | | | 22b. DATE SIGNED Dec 19, 65 | |
| 22c. PHYSICIAN'S NAME (Type) DAVID S MILLER, CAPT, US AF, MC | | | | 22d. ADDRESS USAF HOSP ANDREWS AFB MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-22-65 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION (City, town or county) (State) Pumpkin South Carolina | |
| 24. FUNERAL DIRECTOR W. W. Chambers & Son, 517-11th St. S.E. | | | | 25a. REC'D BY REGISTRAR DEC 27 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL 1010 After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

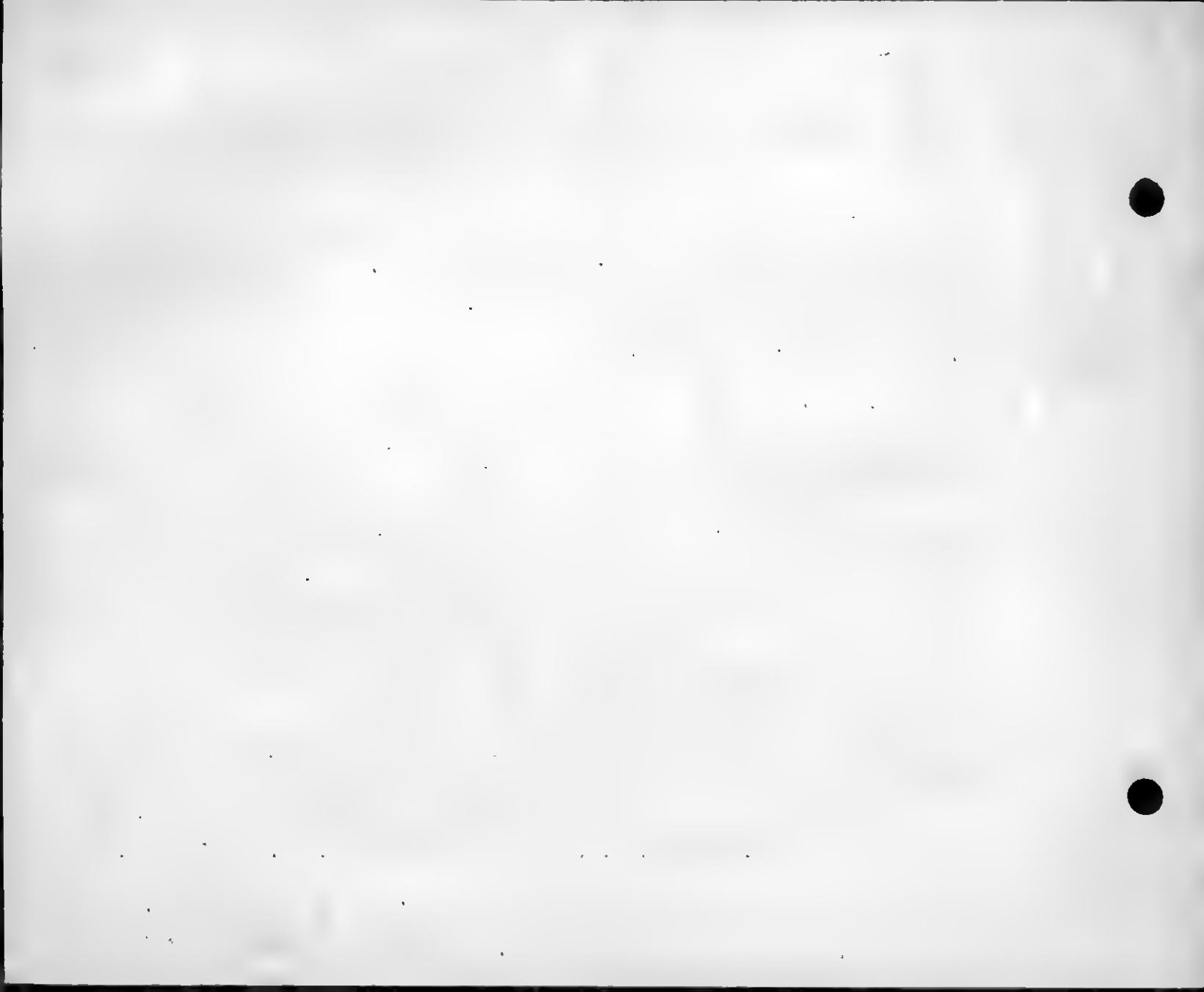
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights d. STREET ADDRESS 324 Terrell Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bernard J. George Sr. | | 4. DATE OF DEATH Month December Day 6 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 28, 1878 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Frescoer and Decorator | | 10b. KIND OF BUSINESS OR INDUSTRY Ret. Frescoer and Decorator | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick H. George | | 14. MOTHER'S MAIDEN NAME Mary | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs Rose Shifflett | | Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Cerebral arteriosclerosis (b) Generalized arteriosclerosis DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial infarction, & cerebral | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 5 , 1965, to Dec. 6 , 19 65, that (I) (we) last saw the deceased alive on Dec. 6 , 19 65, and that death occurred at 12:00 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Don B. Cameron M.D. | | 22b. DATE SIGNED 6 Dec. 1965 | |
| 22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D. | | 22d. ADDRESS 3503 Perry St. Mt. Rainier, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE THEREOF 12-10-65 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | 23d. LOCATION (City, town or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. | | 25a. REC'D BY REGISTRAR DEC 7 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

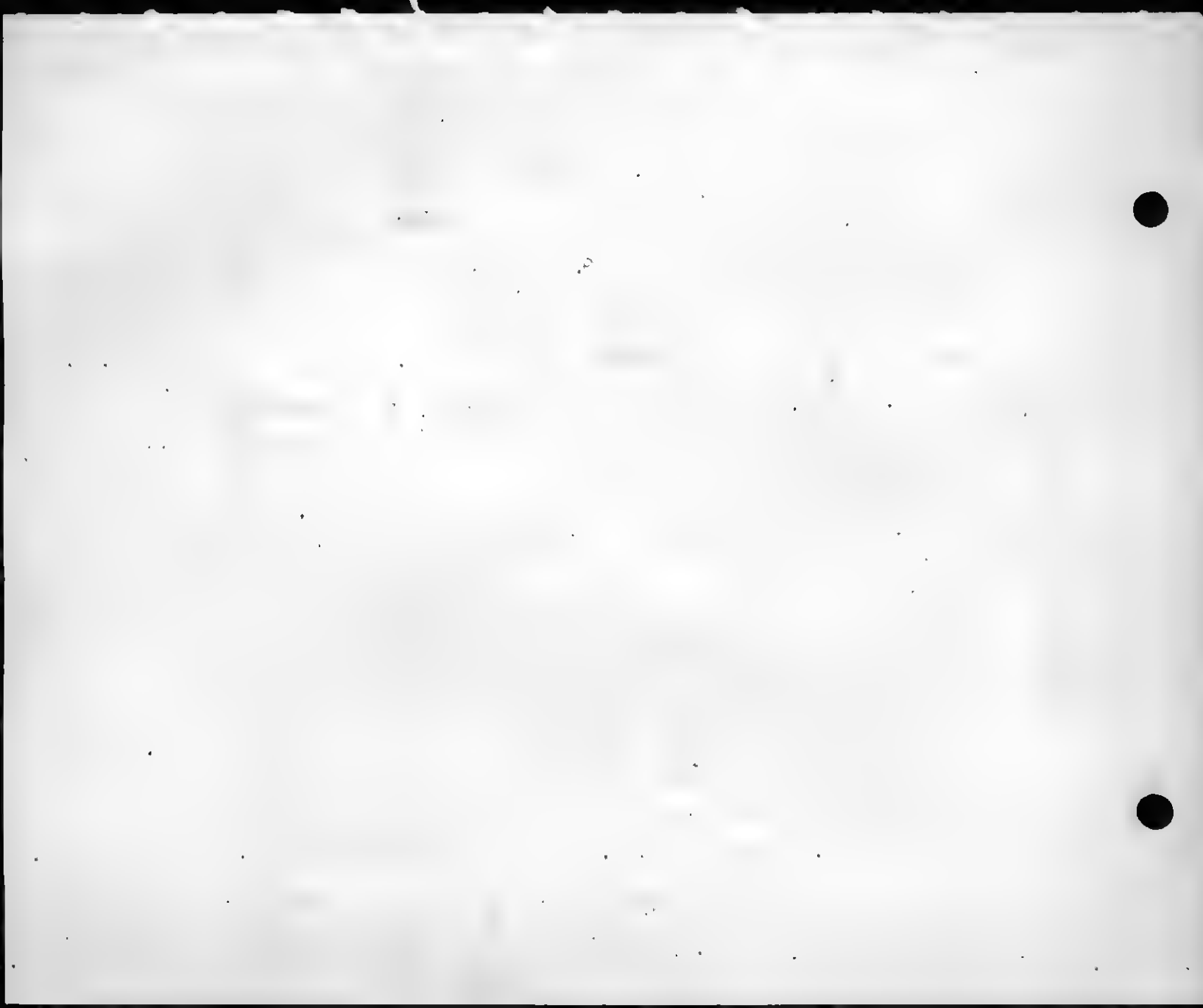


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

16236
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 2 wks. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6902 43rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Margaret A. Gibbons | | 4. DATE OF DEATH Month 12 Day 8 Year 19 65 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-11-91 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 9. AGE (In years last birthday) 74 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) Mass. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME John Fitzgerald | | 14. MOTHER'S MAIDEN NAME Mary A. Smallcomb | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. Medical Record/ daughter in law | |
| 17. INFORMANT Medical Record/ daughter in law | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CHOLECYSTITIS + HEPATIC ABSCESSES AND JAUNDICE DUE TO (b) BILIARY OBSTRUCTION BY CALCULI DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from FEB , 19 65 , to 8 DEC. , 19 65 , that (I) (we) last saw the deceased alive on 8 DEC 19 65 , and that death occurred at 12 PM , from the causes and on the date stated above. 22a. SIGNATURE C. J. Houmann 22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D. 22b. DATE SIGNED 8 DEC. 1965 22d. ADDRESS 4408 Queensbury Road, Riverdale, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-11-65 23c. NAME OF CEMETERY OR CREMATORY Wolvet Cemetery 23d. LOCATION (City, town or county) (State) Washington D. C. 24. FUNERAL DIRECTOR F. Sarchis Sons Hyattsville, Md. 25a. REC'D BY REGISTRAR DEC 16 1965 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

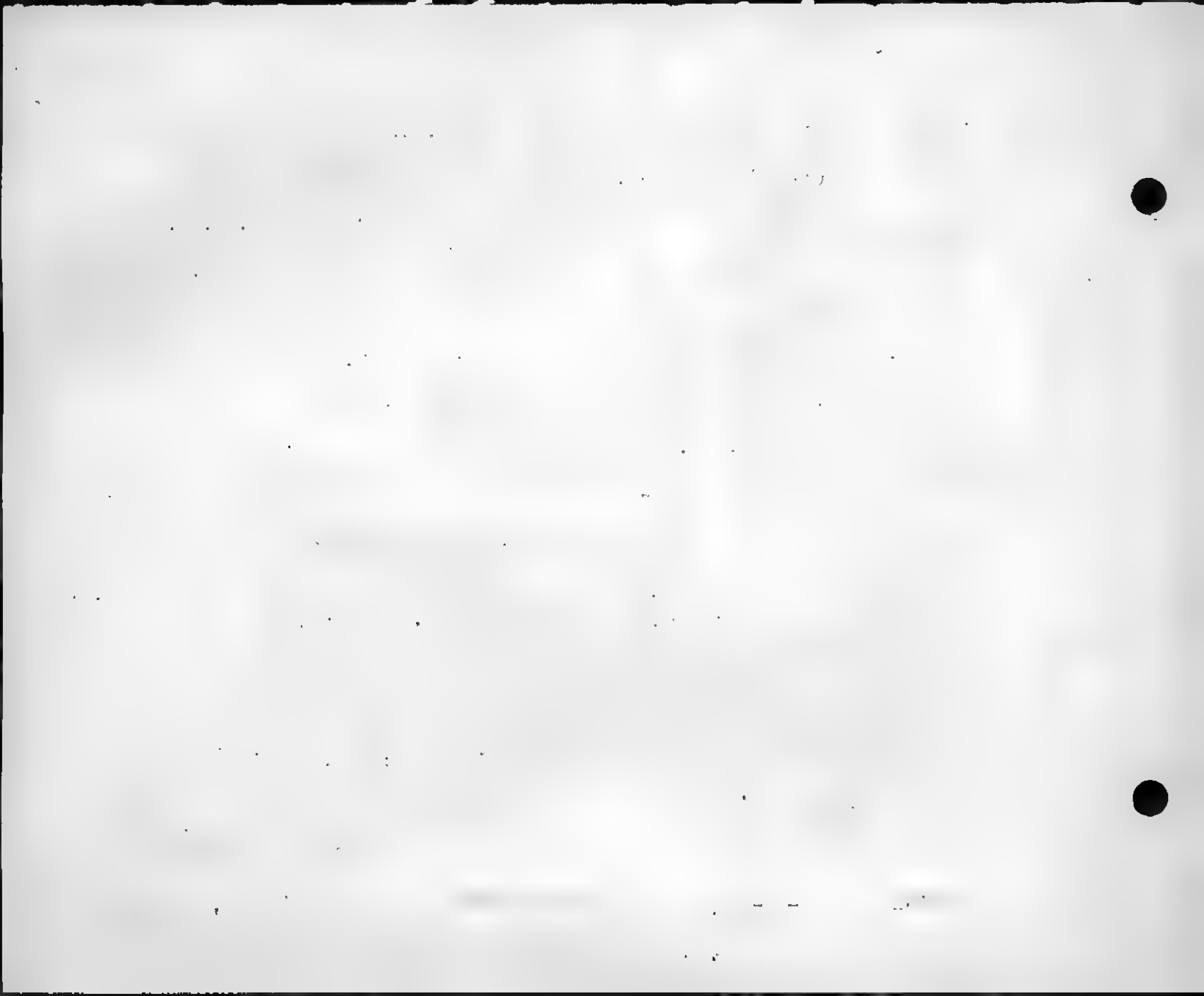


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY D. C. | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b 1 mo. 25 dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | d. STREET ADDRESS 70 Rhode Island Ave. N. E. | |
| 3. NAME OF DECEASED (Type or print) Rosena Gibson | | 4. DATE OF DEATH Dec. 15 1965 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/6/1889 |
| 9. AGE (in years last birthday) 76 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry | |
| 11. BIRTHPLACE (County & State, or foreign country) Alexander Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Handy | | 14. MOTHER'S MAIDEN NAME Hannah Rhodes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Had none | |
| 17. INFORMANT Decedent | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive cardiovascular disease DUE TO (c) arteriolar nephrosclerosis with renal failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pulmonary tuberculosis, chronic pyelonephritis, generalized arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 20 1965 to Dec. 15 1965 , that (I) (we) last saw the deceased alive on Dec. 15 1965 , and that death occurred at 00 A. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/15/65 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-21-1965 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR Malvan & Schuy, Inc., 424-R St. N. W. | | 25a. REC'D BY REGISTRAR DEC 20 1965 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

108538

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|---------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN ID <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> d. STREET ADDRESS <u>7105 Webster St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>H</u> Middle <u>Godfrey</u> Last | | 4. DATE OF DEATH Month <u>Dec.</u> , Day <u>29</u> , Year <u>1965</u> | | 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>14 Mar., 1887</u> | | 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WILMINGTON, DELA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>LEWIS HINKLE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>AMELIA BARKHORN</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | 17. INFORMANT <u>MRS ERMA E HANDS</u> Address <u>COBB ISLAND MD</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5400</u> DUE TO <u>Marked Bilateral pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Multiple bleeding gastric ulcers</u> DUE TO (c) | | | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>12/26</u> , 19 <u>65</u> , that <u>we</u> last saw the deceased alive on <u>12/26</u> , 19 <u>65</u> , and that death occurred at <u>12:55 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | | | | | | | | 22b. DATE SIGNED <u>12/27/65</u> | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>F.E. MESSER</u> | | | | | | | | | | | | 22d. ADDRESS <u>4410 7th Ave, Hyattsville, Md</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>12-31-65</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL</u> | | | | 23d. LOCATION (City, town or county) (State) <u>WILMINGTON, DELAWARE</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale Md</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>JAN 3 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delphi</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Washington</u> D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>2123 I St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Phillip</u> Last <u>Guckert</u> | | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1965</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-20-1870</u> | | 9. AGE (In years last birthday) <u>94</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Plate Enginner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Carl Guckert</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Marguerite R. Guckert</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>William Guckert</u> Address <u>3504 Cedar Drive, Rock Haven, Edgewater, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgical removal of one kidney and prostate.</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <u>R.D. Bauer</u> attended the deceased from <u>1-27</u> , 19 <u>65</u> , to <u>12-13</u> , 19 <u>65</u> , that <u>he</u> last saw the deceased alive on <u>12-13</u> , 19 <u>65</u> , and that death occurred at <u>1:45</u> PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>R.D. Bauer M.D.</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-13-65</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u> | | | | | | 22d. ADDRESS <u>2513 Buck Lodge Rd - Delphi, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>12-15-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Thomas E. Humphrey, Inc.</u> | | | | ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>DEC 17 1965</u> | | | | | | | | | | | |



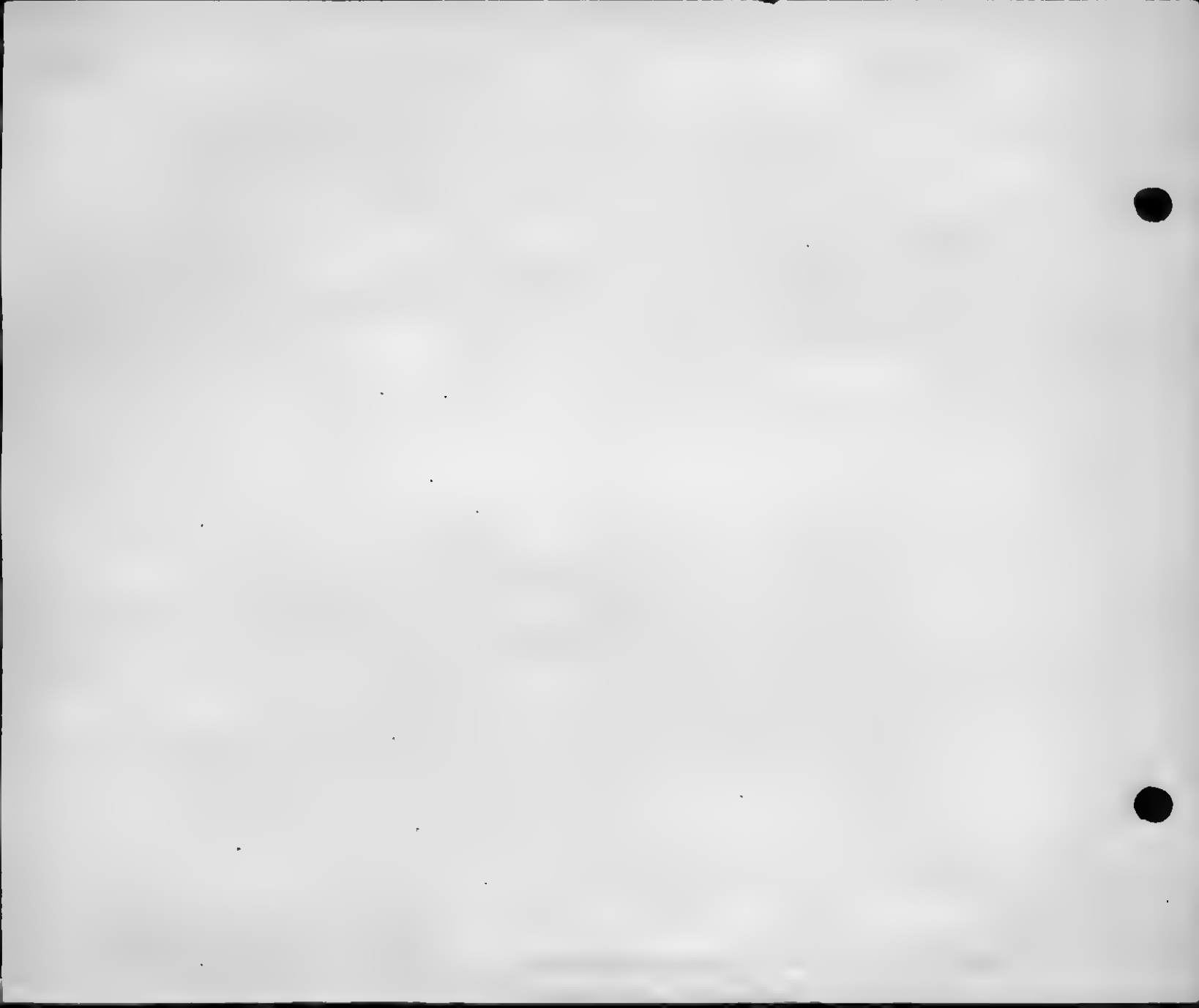
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVERDALE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EUGENE LELAND MEMORIAL HOSPITAL | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRENTWOOD d. STREET ADDRESS 4512 35TH PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) MARY ETHEL HARMAN | | | | | | 4. DATE OF DEATH DECEMBER 8 1965 Last Month Day Year | | | | | |
| 5. SEX FEMALE CAUCASIAN 6. COLOR OR RACE CAUCASIAN 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 8. DATE OF BIRTH NOVEMBER 25, 1974 9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | 11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME JACOB CORP | | | | | | 14. MOTHER'S MAIDEN NAME MARY WELTY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. unk. | | | | | | 17. INFORMANT BESSIE GRAY - DAUGHTER (SAME AS ABOVE) Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1200 DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE (c) GENERAL ARTERIO-SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3:45 P.M. DEC 7 1965 to DEC 8 1965 , that (I) (we) last saw the deceased alive on DEC 7 1965 , and that death occurred at 9:25 AM from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE L W Malin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12-8-65 22c. PHYSICIAN'S NAME (Type) L W Malin M.D. 22d. ADDRESS Riverdale, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Dec 10, 1965 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. Asch's Sons, Hyattsville, Md. ADDRESS Gu.B. 25a. REC'D BY REGISTRAR DEC 13 1965 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

MEDICAL CERTIFICATION

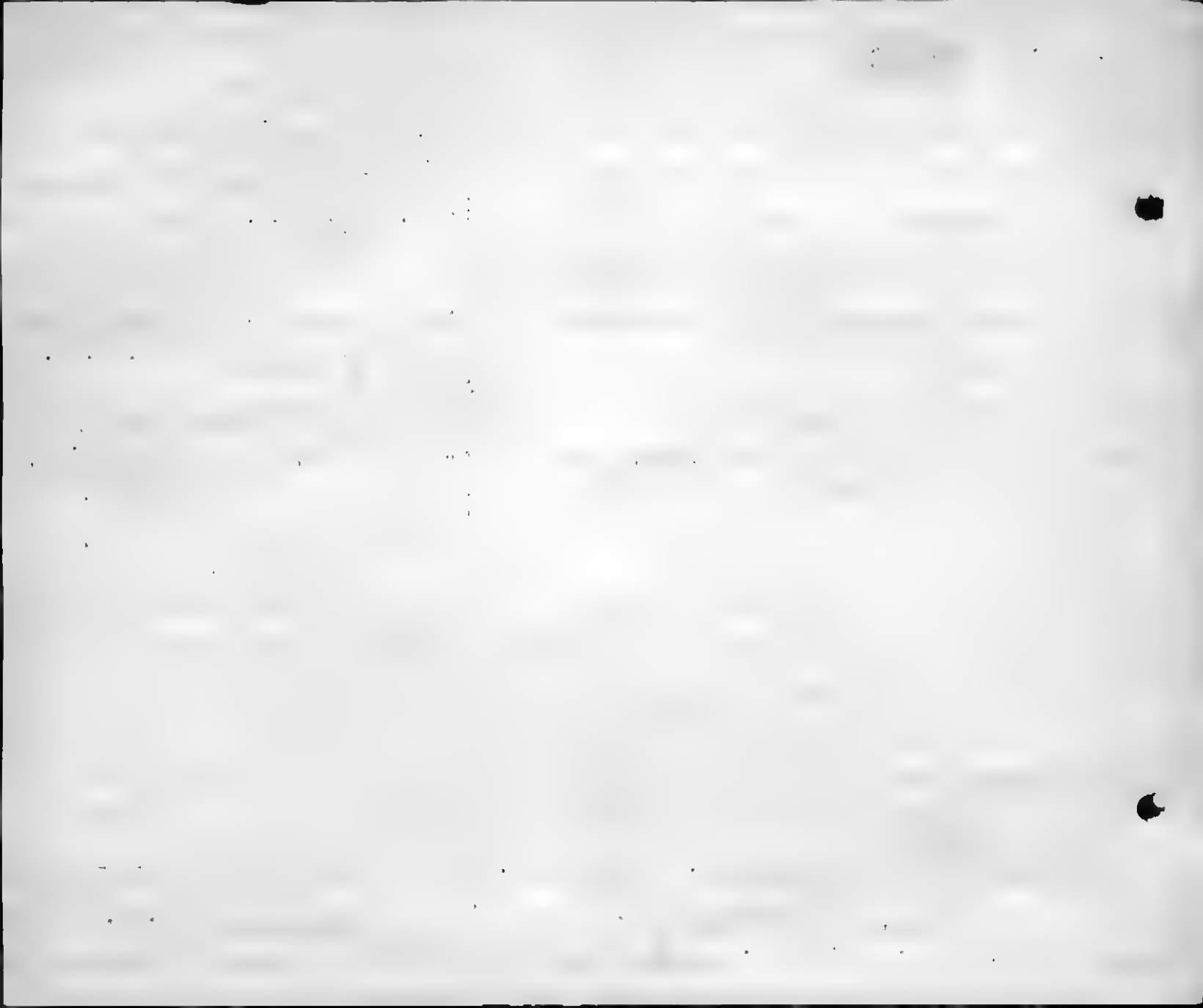


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16841
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>515 3rd. Street, N.E.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> e. LENGTH OF STAY in 1b <u>DOA</u> | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | |
| 3. NAME OF DECEASED (Type or print) <u>James Monroe Luther Haskins</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 65</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2 Jan. 1938</u> |
| 9. AGE (In years last birthday) <u>27</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>12</u> Days <u>17</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>January 2, 1938</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Monroe Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillian Harris</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Lillian Haskins-515 3rd St., N. E.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> <u>451x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rupture of aneurysm of ascending aorta</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a); 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-19-65</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-23-65</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> |
| 23. FUNERAL DIRECTOR <u>John T. Rhines Co., 3015 12th Street, NE</u> | | 24a. REC'D BY REGISTRAR <u>DEC 27 1965</u> 24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



1
FOR STATE
HEALTH DEPT.

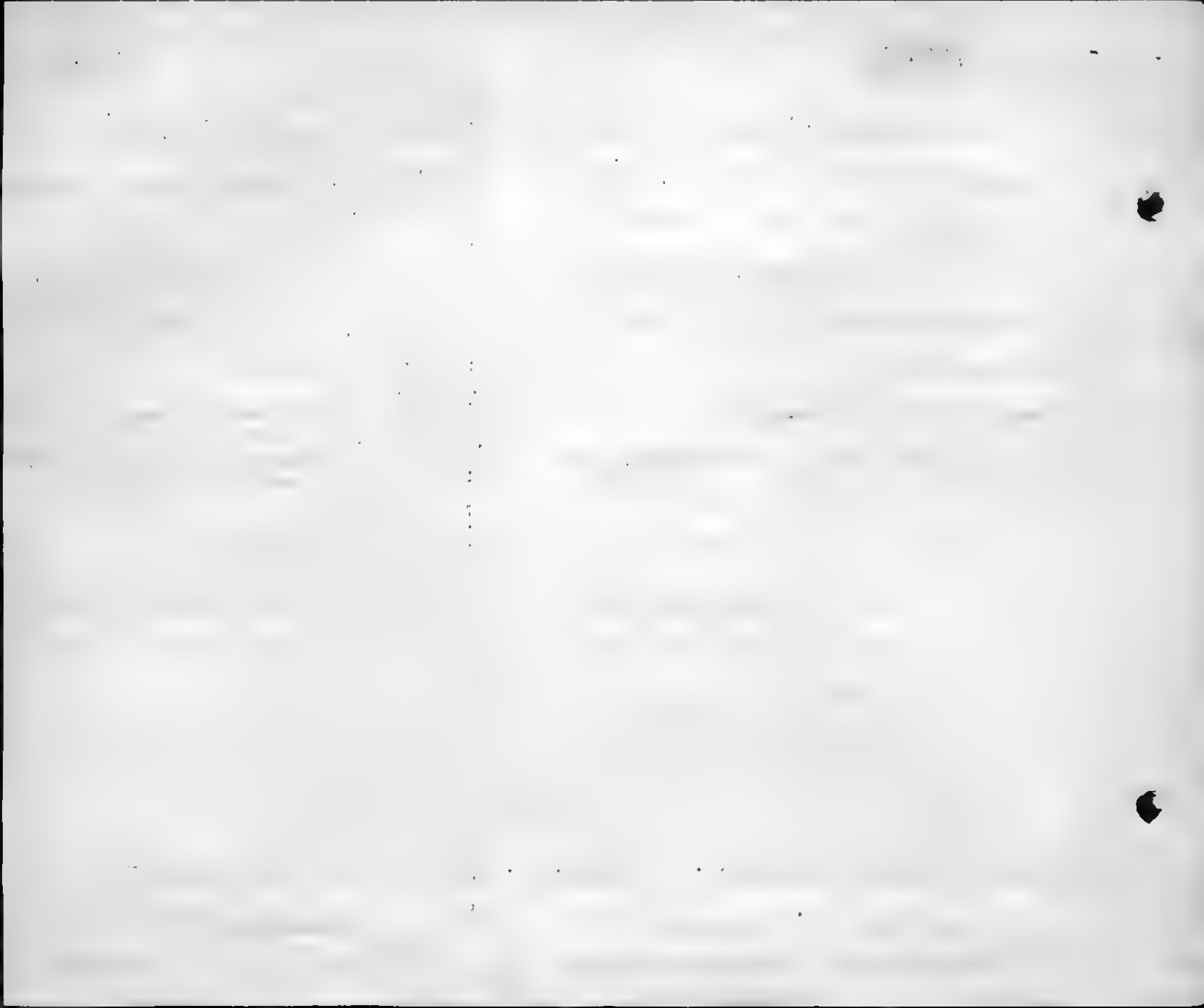
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give flags 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

16842

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood d. STREET ADDRESS 3707 Upshur Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | | | c. LENGTH OF STAY IN 1b | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Anna Margaret Herath | | | | 4. DATE OF DEATH 12 21 19 65 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 23 April 1886 | | 9. AGE (In years last birthday) 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME George Tanner | | | | 14. MOTHER'S MAIDEN NAME K. Schlenke | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address Anna M. Leftwich-Daughter-Same as Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days over 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 12-21-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 24-65 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR Simmons Bros ADDRESS 1661-Good Hope Rd SE Wash DC | | | | 24a. REC'D BY REGISTRAR DEC 27 1965 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

15844

MARYLAND STATE DEPARTMENT OF HEALTH

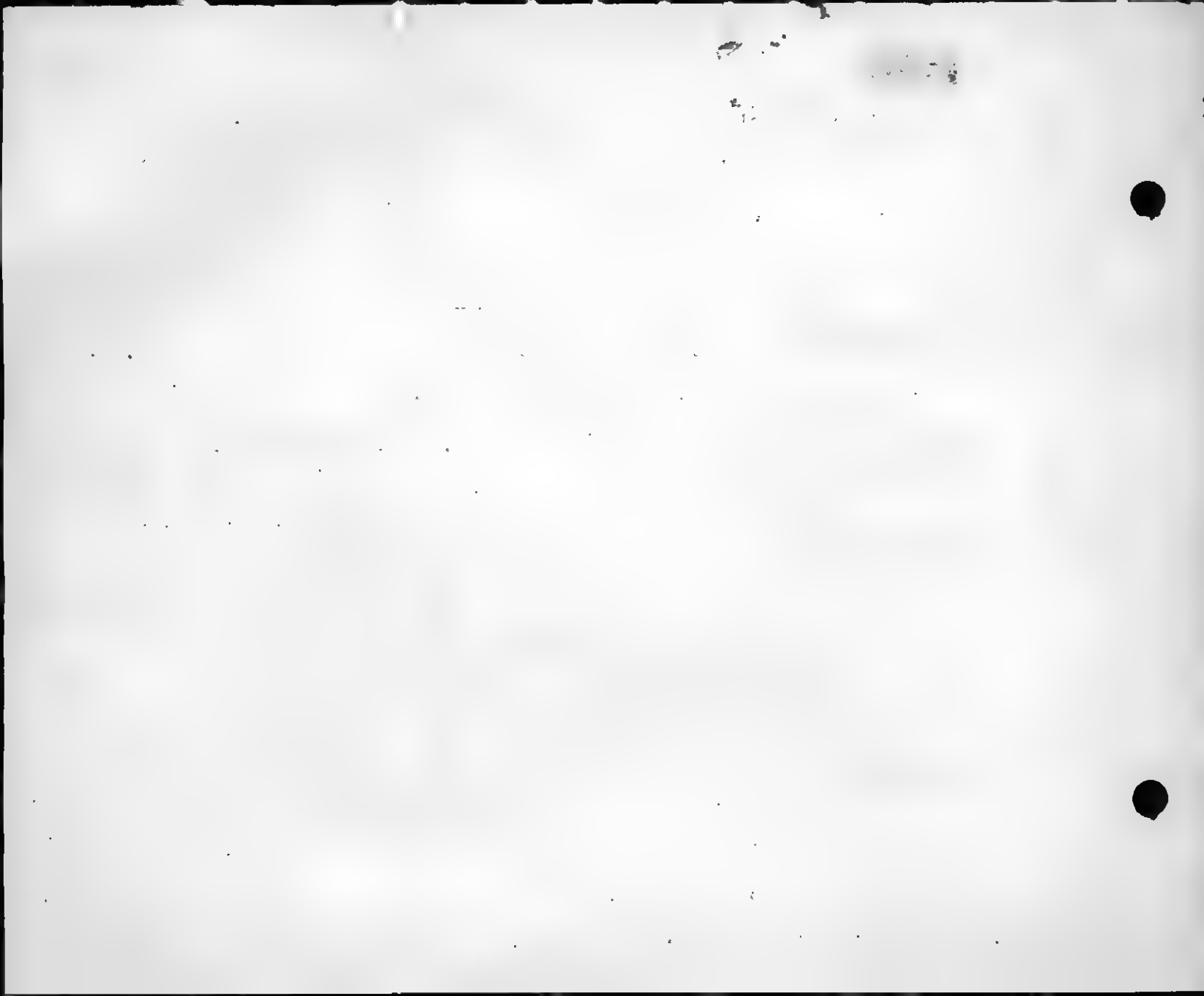
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

26

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b 25 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Y Lanham | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | | | d. STREET ADDRESS 9437 Dubarry Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clifton Bourroughs Hickerson | | | 4. DATE OF DEATH Month Day Year 12 9 1965 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-5-1893 | | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY State Government | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME Hubert Clifton Hickerson | | | | 14. MOTHER'S MAIDEN NAME Nannie ? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. 578 24 8840 | | 17. INFORMANT James H. Hickerson, Son/Medical Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO (b) <i>sinus arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 18 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Nov 14</i> , 1965, to <i>12-9</i> , 1965, that (I) (we) last saw the deceased alive on <i>Dec 8</i> , 1965, and that death occurred at <i>8:45</i> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>L W Mallin</i> | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-9-65 | |
| 22c. PHYSICIAN'S NAME (Type) L W Mallin MD | | | | 22d. ADDRESS 5000 State, 2000 | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 23b. DATE THEREOF 12/13/65 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 13 1965 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MEDICAL CERTIFICATION

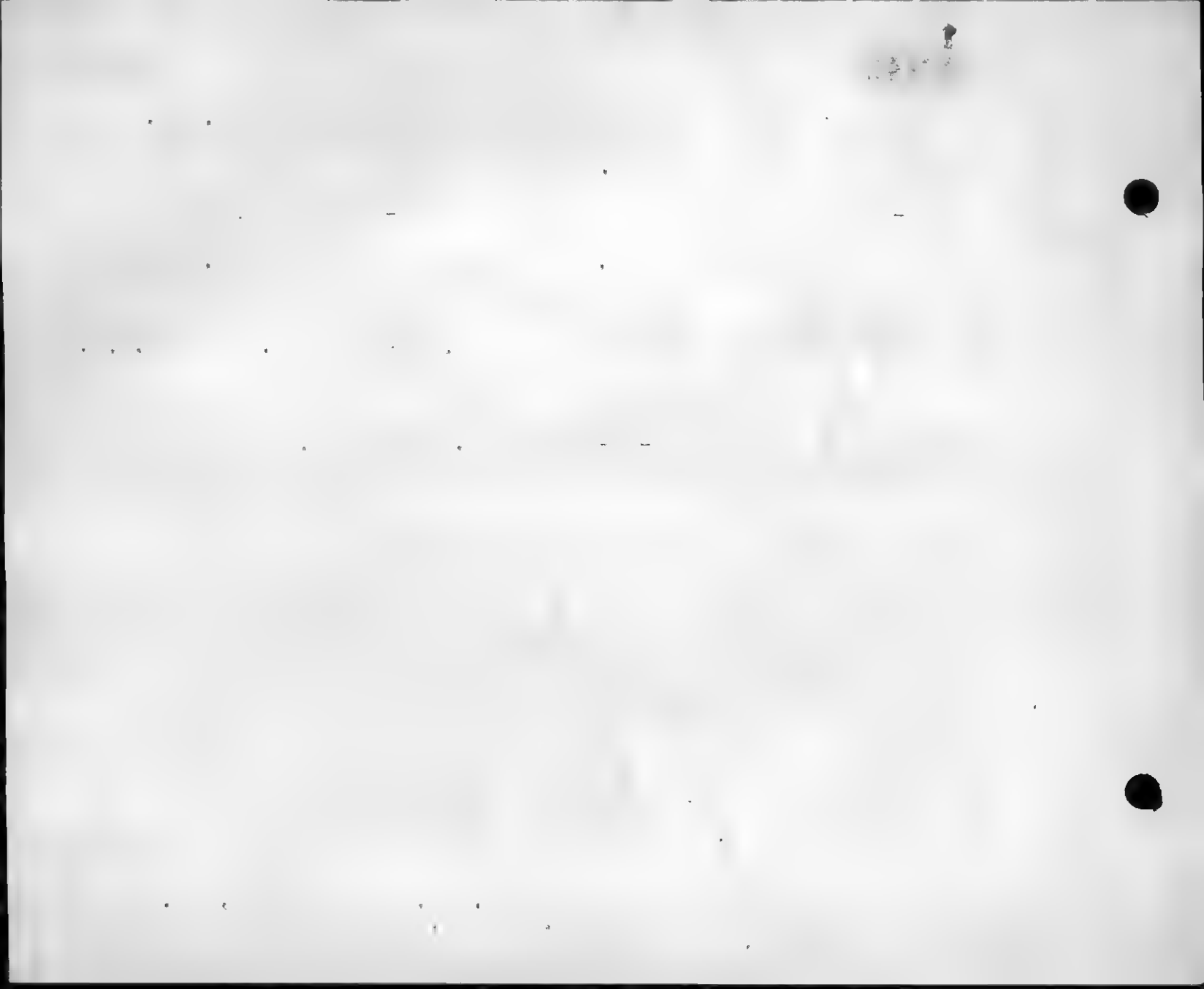


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie c. LENGTH OF STAY IN 1b Dec. 1962 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12301-Kemmerton Lane | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 12301-Kemmerton Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Felix Middle F. Last Hill | | 4. DATE OF DEATH Month Dec. Day 10 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/24/1896 9. AGE (in years last birthday) 69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (County & State, or foreign country) Mt. Pleasant, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Hilinski | | 14. MOTHER'S MAIDEN NAME Mary Orvitsky | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWI | | 16. SOCIAL SECURITY NO. 218-03-9557 | |
| 17. INFORMANT Mrs. Estelle M. Hill (above address) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral tumor (Astrocytoma), left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) temporal lobe. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 1962 to 10 Dec. 1965 , that (I) (we) last saw the deceased alive on 12-8-1965 , and that death occurred at 6:50 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John Cosma | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN COSMA, M.D. | | 22d. ADDRESS 3010 STONY BROOK AVE, BOWIE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/13/1965 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. | 23d. LOCATION (City, town or county) (State) Arlington, Va. |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR DEC 16 1965 | 25b. REGISTRAR'S SIGNATURE John L. Judge |



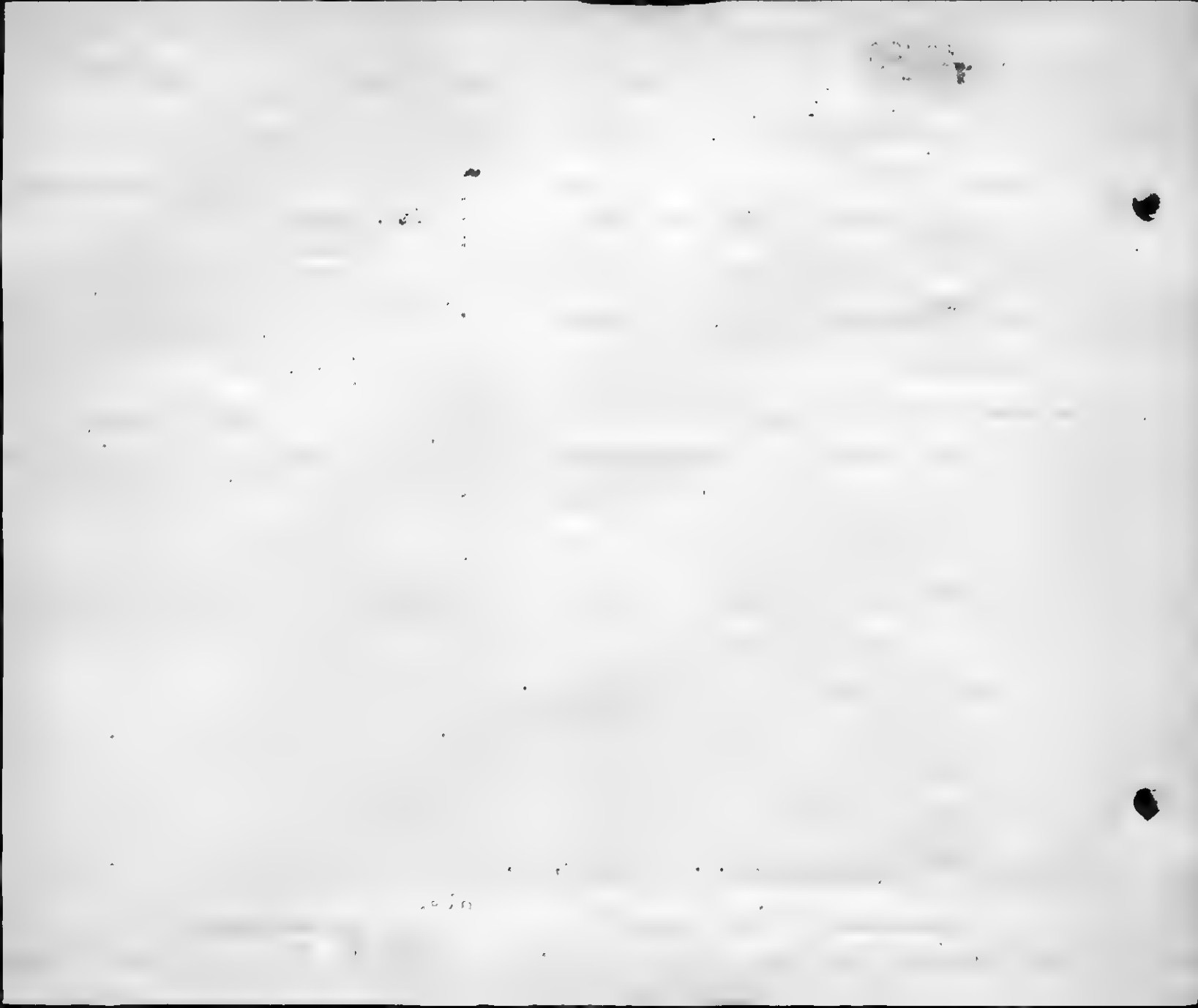
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 74 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 74 hours after death.

VR A15ME
SM 1/63

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | | | e. LENGTH OF STAY IN 1b <u>DOA</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u> | | | | | | d. STREET ADDRESS <u>6502 94th Avenue</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bruce Edward Holzer</u> | | | | | | 4. DATE OF DEATH <u>12 20 19 65</u> | | | | | |
| 5. SEX <u>Male</u> | | | | | | 6. COLOR OR RACE <u>White</u> | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | 8. DATE OF BIRTH <u>8 Aug. 1921</u> | | | | | |
| 9. AGE (In years last birthday) <u>44 1/3</u> yrs. | | | | | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service station operator</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gas station</u> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U S A</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | | | | |
| 13. FATHER'S NAME <u>Howard Holzer</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Lee</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u> | | | | | | 16. SOCIAL SECURITY NO. <u>WW 11</u> | | | | | |
| 17. INFORMANT <u>Carol E Holzer</u> | | | | | | Address <u>Landover Hills, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head.</u> | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>11:30 p.m. 12-19- 19 65</u> | | | | | | | | | | | |
| 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4214 75th Avenue, Landover Hills, Md.</u> | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| DATE SIGNED <u>12-20-65</u> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | | | | | | | | | |
| Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | | | | | | |
| 22b. DATE THEREOF <u>Dec 22, 1965</u> | | | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u> | | | | | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> | | | | | | | | | | | |
| 24a. REC'D BY REGISTRAR <u>DEC 27 1965</u> | | | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | |

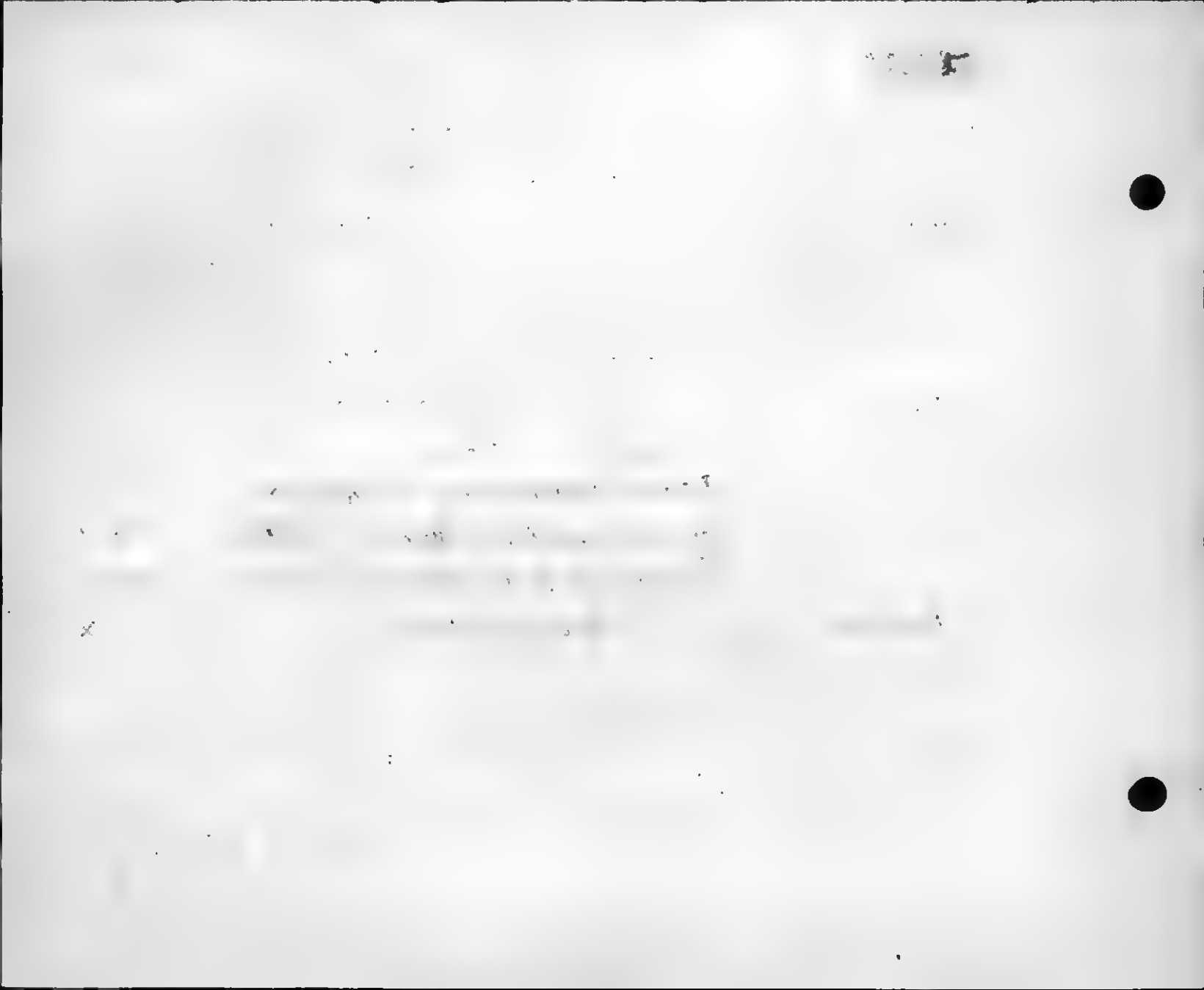
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | c. LENGTH OF STAY IN 1b 3 mo., 29 dys | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | | | | d. STREET ADDRESS 1531 8th St. N. W. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Arthur Hood | | | | | 4. DATE OF DEATH Month Dec. Day 19 Year 19 65 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/18/1889 | | 9. AGE (in years last birthday) 76 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Smithfield, N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Right Hood | | | | | 14. MOTHER'S MAIDEN NAME Amade Saunders | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT decedent | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4-2-21 OUE TO (b) ARTERIO SCLEROTIC HEART DISEASE OUE TO (c) GENERALIZED ARTERIOSCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA, PYELONEPHRITIS | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/20 1965 , to 12/19 , 19 65 , that (I) (we) last saw the deceased alive on 12/19 19 65 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Moe Weiss | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/19/65 | | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12-23-65 | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Smithfield, N.C. | | 23d. LOCATION (City, town or county) (State) | | |
| 24. FUNERAL DIRECTOR P.N. Horton Co. 1324 1/2 St. N.W. | | | | | 25a. REC'D BY REGISTRAR DEC 27 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

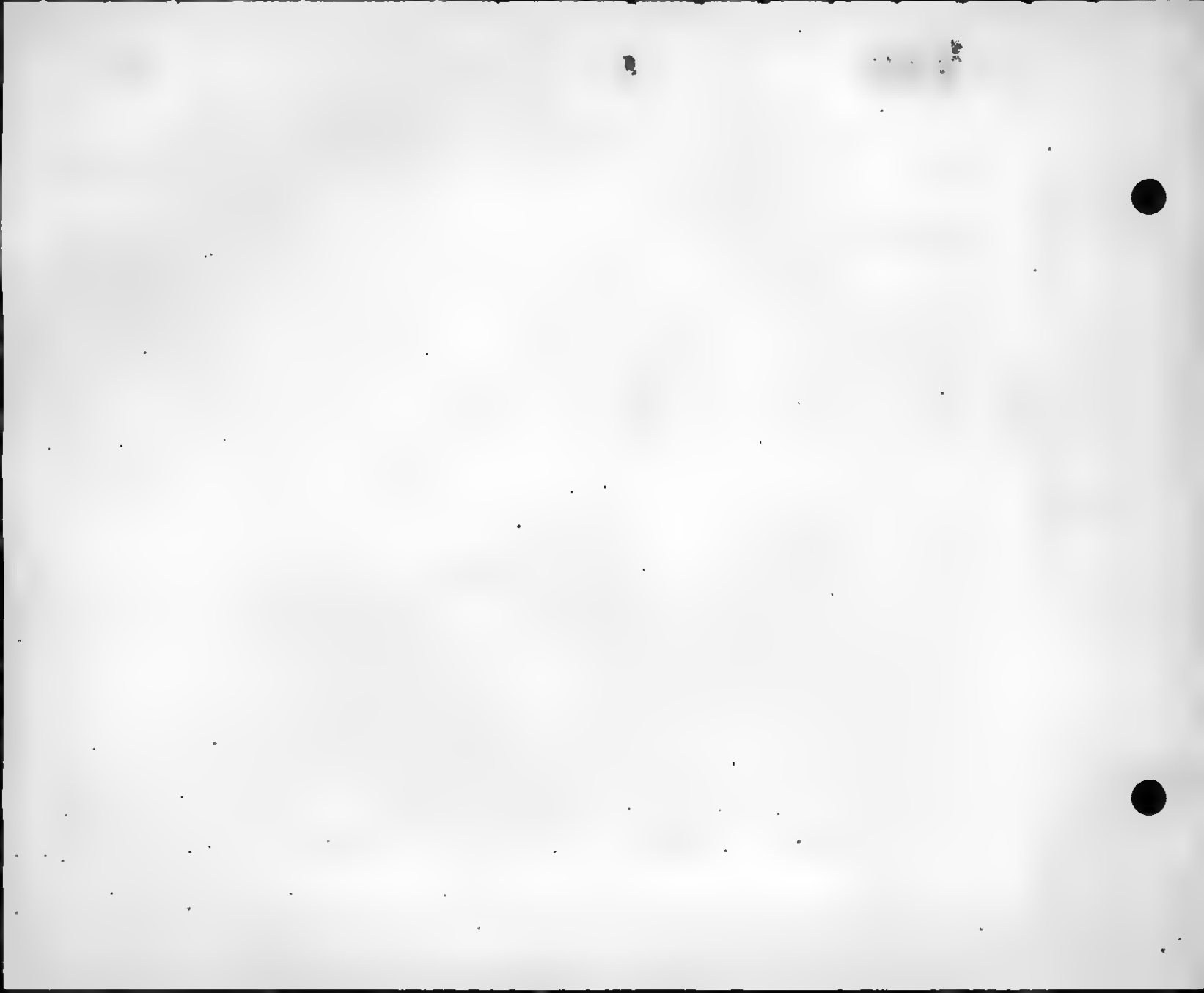


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------|------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> 16848 Item #2 a, e & d form 1-12-66 pc </div> | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 6 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MISSISSIPPI f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) COLUMBUS/AIR FORCE BASE d. STREET ADDRESS Rt. #2 Church Rd. g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First JOBE | | Middle NMI | | Last HOWELL | | 4. DATE OF DEATH Month DECEMBER Day 30 Year 1965 | | |
| 5. SEX MALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 18 May 1919 | | 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER | | | | 10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOBE R HOWELL | | | | | | 14. MOTHER'S MAIDEN NAME BLANCH R. Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO. 302-14-0330 | | 17. INFORMANT Address Military Records, Andrews AFB, Wash, DC | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest (b) cachexia (c) carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from 24 Dec , 19 65 , to 30 Dec , 19 65 , that (X) (we) last saw the deceased alive on 30 Dec , 19 65 , and that death occurred at 12:28 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Thomas J. Fiene | | | | | | | | | | 22b. DATE SIGNED 30 Dec 65 | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS J. FIENE, CAPT, USAF | | | | M.D. <input checked="" type="checkbox"/> MC <input type="checkbox"/> | | ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input checked="" type="checkbox"/> | |
| | | | | 22d. ADDRESS USAF Hospital Andrews, Wash, D.C. | | | | | | 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 1-5-66 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. Inc. 517-11th St. P.E. | | | | 25a. REC'D BY REGISTRAR IAN 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

MEDICAL CERTIFICATION



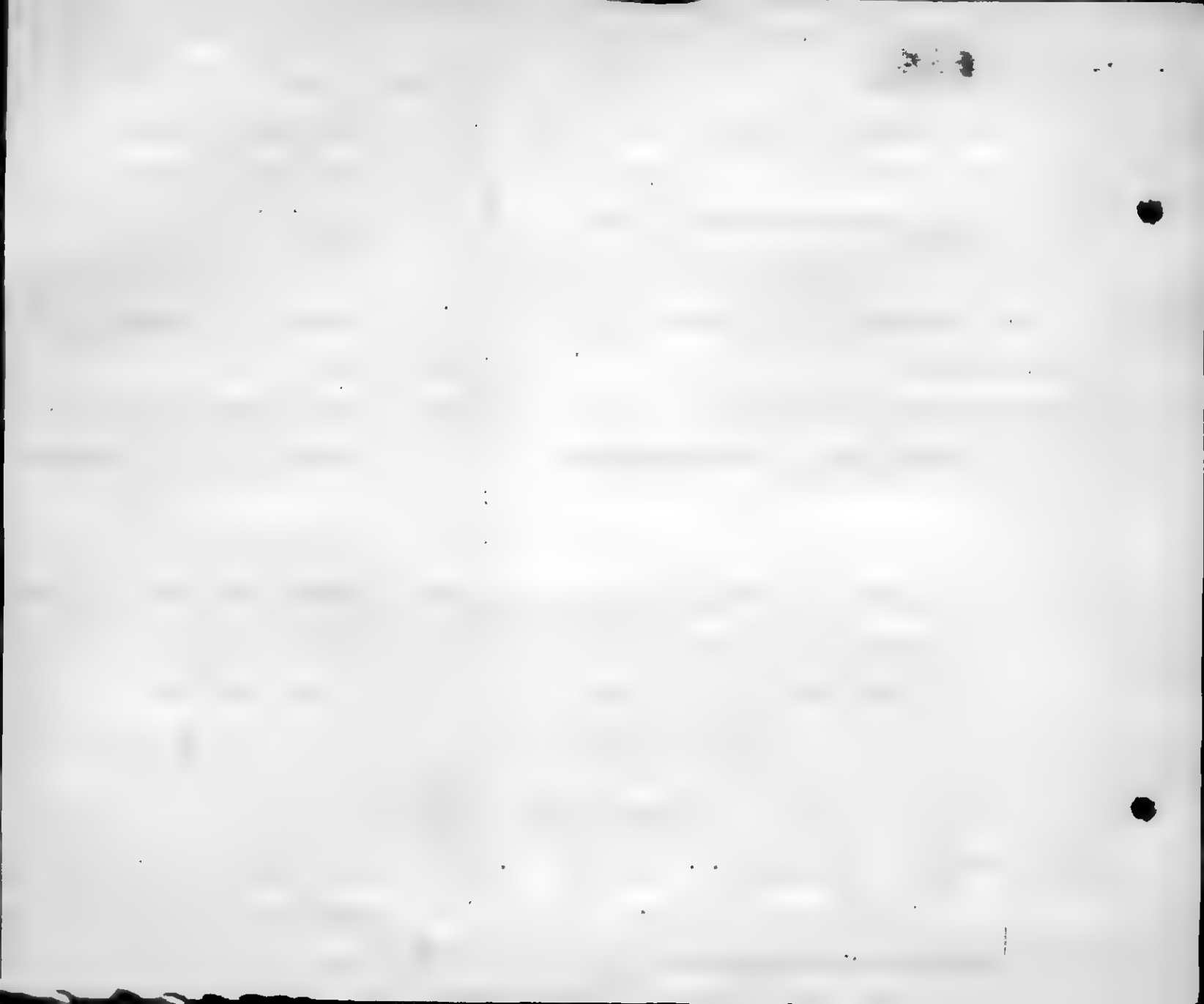
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MEDICAL CERTIFICATION

| <div> <div>8</div> <div>1</div> </div> <div> <div>16849</div> <div>1231</div> </div> | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>32 Prince George General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> d. STREET ADDRESS <u>12 Fete Drive S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> <u>Horace</u> <u>Hungerford</u> First Middle Last | | | 4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>19 65</u> | | | 5. SEX <u>Male</u> | | | 6. COLOR OR RACE <u>White</u> | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>19 Jan. 1900</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME <u>Nathaniel T. Hungerford</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mistretta</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | | | | | | | |
| 17. INFORMANT <u>Wife</u> Address <u>Viola T. Hungerford Same as Item #2</u> | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | |
| 20f. (City or town) | | | | | | 20g. (County) | | | | | | | | |
| 20h. (State) | | | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> | | | | | | DATE SIGNED <u>12-28-65</u> | | | | | | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | | | | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | 22b. DATE THEREOF <u>Dec 30-1965</u> | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u> | | | | | | 22d. LOCATION (City, town, or county) <u>Oxon Hill, Maryland</u> | | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Simmmons Bros</u> | | | | | | ADDRESS <u>1661-Good Hope Rd SE Wash DC</u> | | | | | | | | |
| 24. REC'D BY REGISTRAR <u>DEC 30 1965</u> | | | | | | 24b. REGISTRAR'S SIGNATURE <u>John Carlos Judge</u> | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND #6850 | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel General Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtsville d. STREET ADDRESS 14901 Columbia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | | 8. DATE OF BIRTH Sept 4 1908 57 yrs. 9. AGE (In years last birthday) 57 yrs. 11. BIRTHPLACE (County & State, or foreign country) Marion, Georgia 12. CITIZEN OF WHAT COUNTRY? USA | | | 4. DATE OF DEATH 12 13 1965 Month Day Year IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | |
| 13. FATHER'S NAME Ernest Arnett 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 17. INFORMANT Karen Hurst, Burtsville Md Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 572.1 DUE TO Colectomy Operation 10 days (b) RUPTURED DIVERTICULUM 33 days (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/18, 1946, to 12/13, 1965, that (I) (we) last saw the deceased alive on 12/13, 1965, and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE J.M. Warren 22c. PHYSICIAN'S NAME (Type) J.M. Warren | | | | | | 22b. DATE SIGNED 12/15/65 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Laurel Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 12-16-65 | | 23c. NAME OF CEMETERY OR CREMATORY St Marks Cem | | | 23d. LOCATION (City, town or county) (State) Fairland Md | | | |
| 24. FUNERAL DIRECTOR Bellitt Danaher ADDRESS Laurel Md | | | | | | 25a. REC'D BY REGISTRAR DEC 17 1965 DATE | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



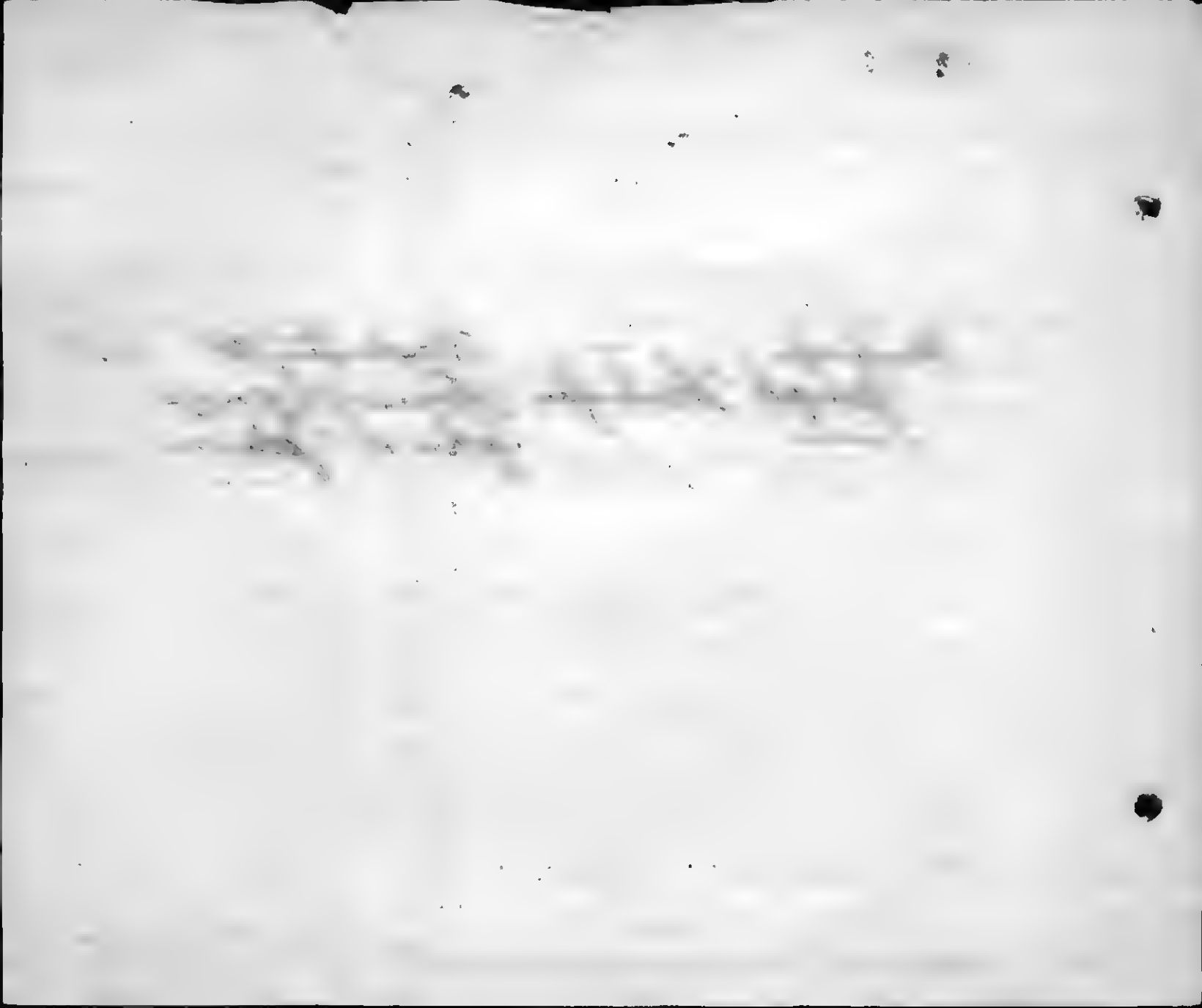
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

| <div> <div>16851</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>2232</div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|---------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|---------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fairmont Heights</u> d. STREET ADDRESS <u>5802 Sheriff Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>NELLIE LOUISE JACKSON</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1965</u> | | | 5. SEX <u>Female</u> | | | 6. COLOR OR RACE <u>Negro</u> | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>26 June 1940</u> | | | 9. AGE (In years last birthday) <u>25</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>65</u> | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington DC</u> | | | | | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Joseph Washington</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Louise Spriggs</u> | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>John A. Jackson</u> | | | | | | 17. INFORMANT <u>John A. Jackson</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>From metastatic carcinoma of brain and lungs</u> DUE TO (c) <u>From Hypernephroma left kidney</u> | | | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u> <u>unknown</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> | | | | | | EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | | | | DATE SIGNED <u>12-2-65</u> | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-6-65</u> | | | | | | 22b. DATE THEREOF <u>12-6-65</u> | | | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u> | | | | | | 22d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd NE Wash DC</u> | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Henry S. Washington & Sons - 4925 Pleanan</u> | | | | | | 24a. REC'D BY REGISTRAR <u>DEC 7 1965</u> | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION



NR A15 (4)
20M 1/65

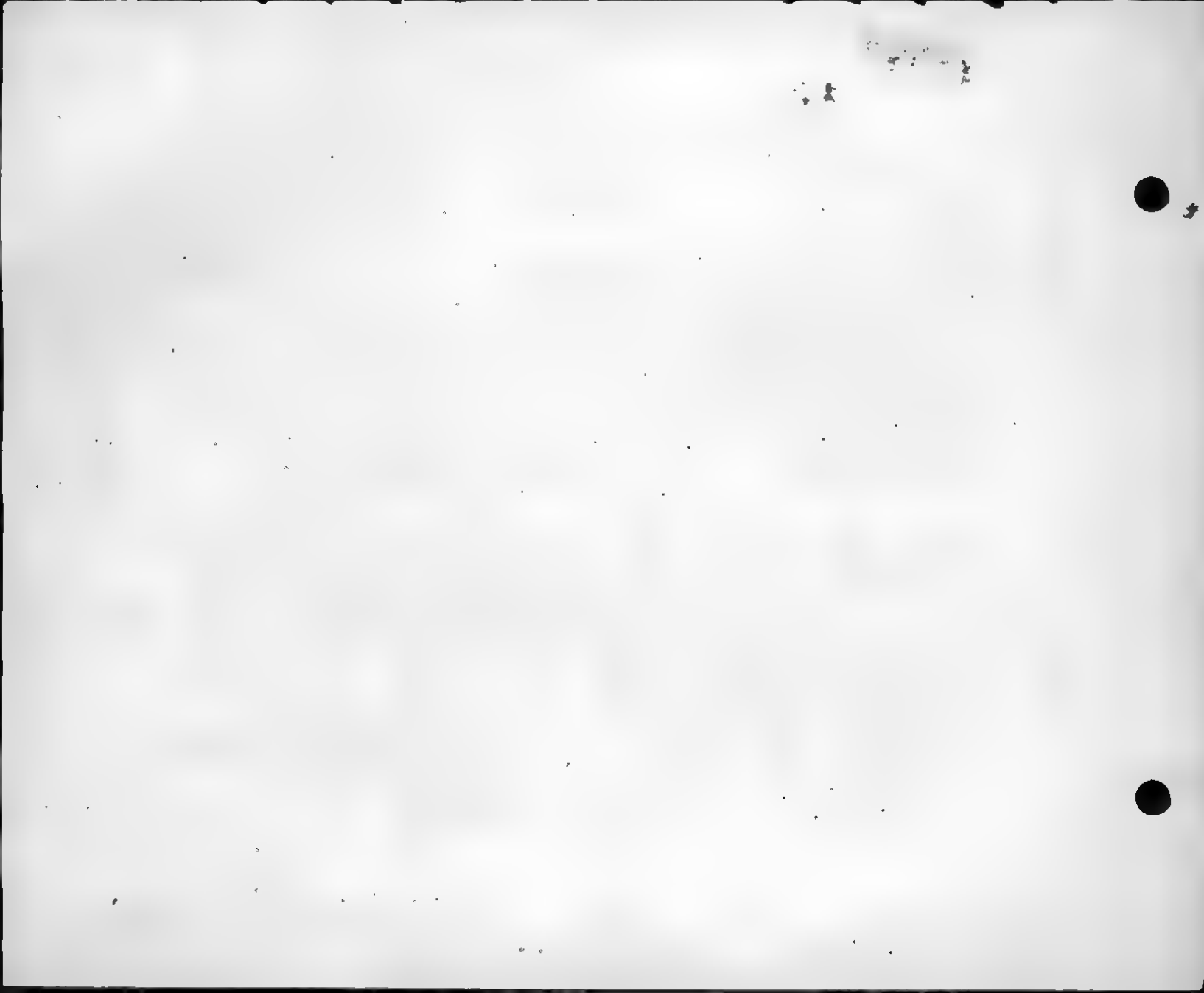
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Pr. Geo. S. | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine | | c. LENGTH OF STAY in 1b 1 1/2 time | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brandywine-Waldorf Med. Clinic | | | | d. STREET ADDRESS Rt. 3-Box 363 | |
| 3. NAME OF DECEASED (Type or print) Willie Joseph | | First Middle Last Johnson | | 4. DATE OF DEATH Month Day Year December 1 1965 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 9, 1915 | 9. AGE (In years last birthday) 50 | IF UNDER 1 YEAR Months Days 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodial | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Prince George's Co. Md. | |
| 13. FATHER'S NAME Willie Johnson | | | 14. MOTHER'S MAIDEN NAME Henrietta Smith | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 213020-5151 | | 17. INFORMANT Address Mrs. Gladys Porter-Rt. 3-Box 363 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 44-24 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardiovascular Disease DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6/11, 1965 , to 12/1, 1965 , that (I) (we) last saw the deceased alive on 11/1 1965 , and that death occurred at 7:30 PM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Thomas L. Fieldson | | | | 22b. DATE SIGNED 1 Dec 1 1965 | |
| 22c. PHYSICIAN'S NAME (Type) Thomas L. Fieldson | | | | 22d. ADDRESS Brandywine, Md. 20613 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 4, 1965 | 23c. NAME OF CEMETERY OR CREMATORY Gibbons Meth. Ch. Cem. Brandywine, Md. | 23d. LOCATION (City, town or county) (State) | | |
| 24. FUNERAL DIRECTOR Martell Adams | | ADDRESS Aquasco, Md. | | 25a. REC'D BY REGISTRAR DEC 7 1965 | 25b. REGISTRAR'S SIGNATURE Charles Judge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16853

1635

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| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b m 2 hrs 10 m d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hillside d. STREET ADDRESS 1525 59th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED First Middle Last Baby Boy Kavadias 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 21 Dec., 1965 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A | | | 4. DATE OF DEATH Month Day Year Dec. 21 19 65 9. AGE (In years last birthday) yrs. Months Days Hours Min. x2x 2 10 13. FATHER'S NAME William Jerry Kavadias 14. MOTHER'S MAIDEN NAME Ifigenia Rousson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Presumed acute myocardial infarction</i> DUE TO (b) <i>atelectasis of the lungs</i> DUE TO (c) <i>39 hrs; C to comp. 22 hrs</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>maternal circulate infarction.</i> 19. WAS AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 21, 19 65 to Dec. 21, 19 65, that (I) (we) last saw the deceased alive on Dec. 21, 19 65, and that death occurred at 2:20 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>H. E. Altman</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Harry Earle Altman, M.D. 22d. ADDRESS 2025 Eye St. N.W. Washington 7, D.C. | | | | 22b. DATE SIGNED 12/21/65 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE THEREOF 12/24/65 | | 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp. Cheverly, Maryland | | | |
| 24. FUNERAL DIRECTOR <i>Harry W. Penn, Jr.</i> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>J. J. Jones</i> DATE DEC 28 1965 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|---------------------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE 45 DAYS c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ALEXANDRIA 23X-3 d. STREET ADDRESS 632 NORTH RIPLEY ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MERLE ANNA KELLER | | | 4. DATE OF DEATH DECEMBER 3 1965 | | | 5. SEX FEMALE | | | 6. COLOR OR RACE CAUC | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 11 APRIL 1898 | | | 9. AGE (in years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Nurse | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | | | | | 11. BIRTHPLACE (County & State, or foreign country) ST MARYS COUNTY MD | | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | |
| 13. FATHER'S NAME GEORGE CLARENCE THOMPSON | | | | | | 14. MOTHER'S MAIDEN NAME MARY AGNES WIBLE | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | | 16. SOCIAL SECURITY NO. 577-56-6834 | | | | | | 17. INFORMANT DAUGHTER | | | | | | Address SAME AS ITEM #2 | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 5810 DUE TO Bleeding esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cirrhosis of liver (b) (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours Years | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1965 , to Dec 4, 1965 , that (I) (we) last saw the deceased alive on Dec 4, 1965 , and that death occurred at 7 AM , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Charles D Phelps | | | | | | | | | | | | 22b. DATE SIGNED 4 Dec 65 | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES D PHELPS, CPT USAF MC | | | | | | | | | | | | 22d. ADDRESS USAF HOSP ANDREWS WASH DC 20331 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF Dec 7, 1965 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. | | | | | | 23d. LOCATION (City, town or county) (State) Arlington Va | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. | | | | | | | | | | | | ADDRESS 517-11th St SE Wash DC | | | | | | 25a. REC'D BY REGISTRAR DEC 6 1965 | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

MEDICAL CERTIFICATION

1951



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16855

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1237

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 901 67th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Kredeio | | First Kredeio | | Middle Kelliebrew | | Last Kelliebrew | | 4. DATE OF DEATH Month December Day 14 Year 19 65 | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 22, 1965 | | 9. AGE (in years last birthday) yrs. 2 Months 22 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Terry R. Ingraham | | | | 14. MOTHER'S MAIDEN NAME Mary Kelliebrew | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Mary Kelliebrew Address Same as 2.D | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and dehydration, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u>11</u> (this hospital) attended the deceased from <u>Nov. 17</u> , 19 <u>65</u> , to <u>Dec. 14</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 14</u> , 19 <u>65</u> , and that death occurred at <u>3:04 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Thomas A. Christensen | | | | M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED 12/15/65 | |
| 22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D. | | | | 22d. ADDRESS 6905 Baltimore Ave. College Park, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12-18-65 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. | | 23d. LOCATION (City, town or county) (State) Highland Pk. Md. | | | |
| 24. FUNERAL DIRECTOR H.S. Washington | | | | ADDRESS Sm 4925 Dean Ave NE | | 25a. REC'D BY REGISTRAR DEC 21 1965 | | 25b. REGISTRAR'S SIGNATURE Charles J. J. | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16856

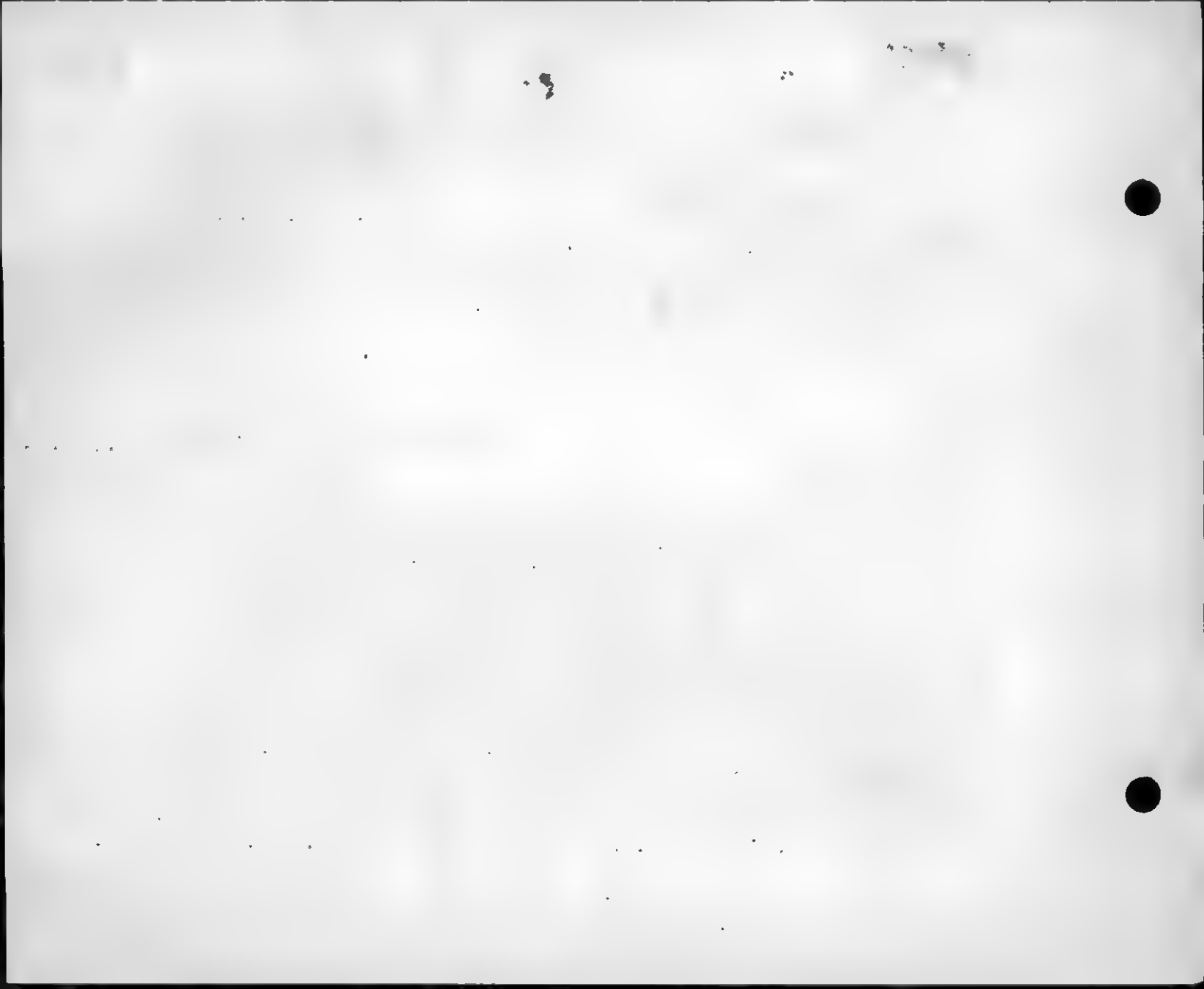
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1238

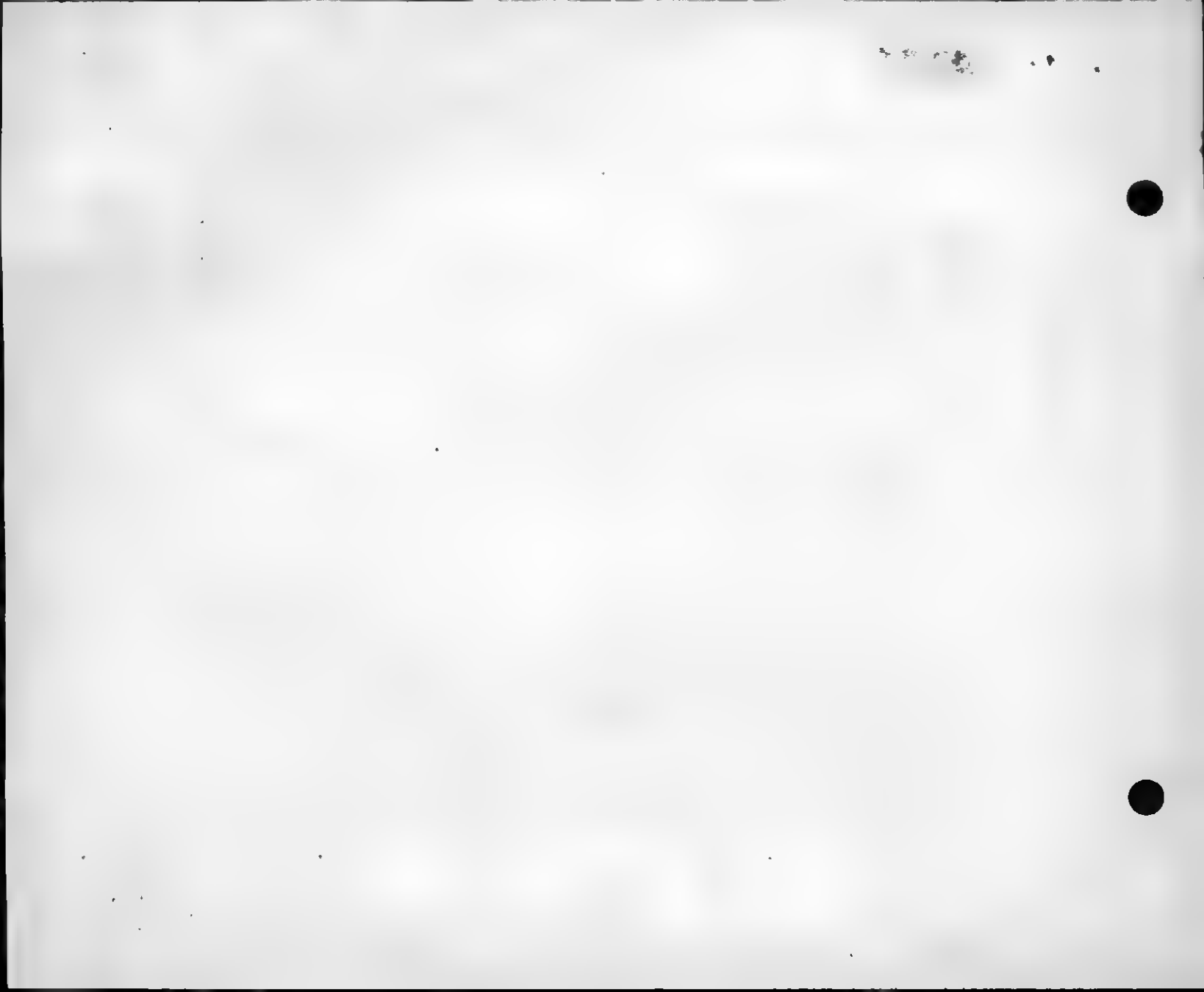
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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 5900 L. Street N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Rosie Franklin | | 4. DATE OF DEATH Month December Day 17 Year 19 65 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 25 1877 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Private | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Alice Lewis | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | | | | |
| 17. INFORMANT Josephine Blake | | Address 5341 Hunt Pl., N.E. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 4701 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Myocardial infarction, acute DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 11 , 19 65 , to Dec. 17 , 19 65 , that (I) (we) last saw the deceased alive on Dec. 17 , 19 65 , and that death occurred at 3:30 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Don B. Cameron | | 22b. DATE SIGNED Dec. 17, 1965 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D. | | 22d. ADDRESS 3503 Perry St., Mt. Rainier, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12-21-65 | | 23b. DATE THEREOF 12-21-65 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. | | 23d. LOCATION (city, town or county) (State) Suitland Rd Md | | | | | |
| 24. FUNERAL DIRECTOR H.S. Washington Sons | | 25a. REC'D BY REGISTRAR DEC 23 1965 | | | | | |
| ADDRESS 4925 Deane One N 3 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 16857 CERTIFICATE OF DEATH 239 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | c. LENGTH OF STAY IN 1b <u>7 hr. 57 min</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | | e. STREET ADDRESS <u>7702 Alpine Street S.E.</u> | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Knight</u> | | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1965</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>December 3, 1965</u> | | 9. AGE (In years last birthday) yrs. <u>7</u> Mths. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Prince George's, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walter Knight</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Joyce Dennison</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>--</u> | | 17. INFORMANT <u>Walter J. Knight</u> Address <u>Same as Item #2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>--</u> DUE TO (c) <u>--</u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>birth</u> , 19 <u>65</u> , to <u>12-3-65</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9:30 AM</u> 19 <u>65</u> and that death occurred at <u>12:30</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>December 4-1965</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>L. A. Jansa</u> | | | | | 22d. ADDRESS <u>7403-Varnum St. Landover Hills Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>Dec. 6-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Simmons Bros.</u> | | | | | 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|--|
| 16858 CERTIFICATE OF DEATH 1940 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u> c. LENGTH OF STAY IN 1b <u>Chenery</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Prince George Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balt.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>1253 Linden Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES ARTHUR KOONS</u> | | | 4. DATE OF DEATH <u>12 20 1965</u> | | | 5. SEX <u>M</u> | | | 6. COLOR OR RACE <u>W</u> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>Aug 16 1902</u> | | | 9. AGE (In years last birthday) <u>63 yrs.</u> | | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative asst. Dept of Army</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US.</u> | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>James Alfred Koons</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Lilly May Smith</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | | | | |
| 17. INFORMANT <u>Emily M. Koons</u> | | | | | | Address <u>Arbutus Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Gen. Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10 yrs.</u> <u>10 yrs.</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | | | (County) | | | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>39</u> , to <u>12/20</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>65</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>J M Warren</u> | | | | | | | | | | | |
| 22b. DATE SIGNED | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u> | | | | | | | | | | | |
| 22d. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>12-23-65</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Madamand's Memorial</u> | | | |
| 23d. LOCATION (City, town or county) <u>Dorsey Md</u> | | | | (State) | | | | | | | |
| 24. FUNERAL DIRECTOR <u>William S. Sweeney</u> | | | | ADDRESS <u>Laurel Md</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 27 1965</u> | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>W. S. Sweeney</u> | | | |

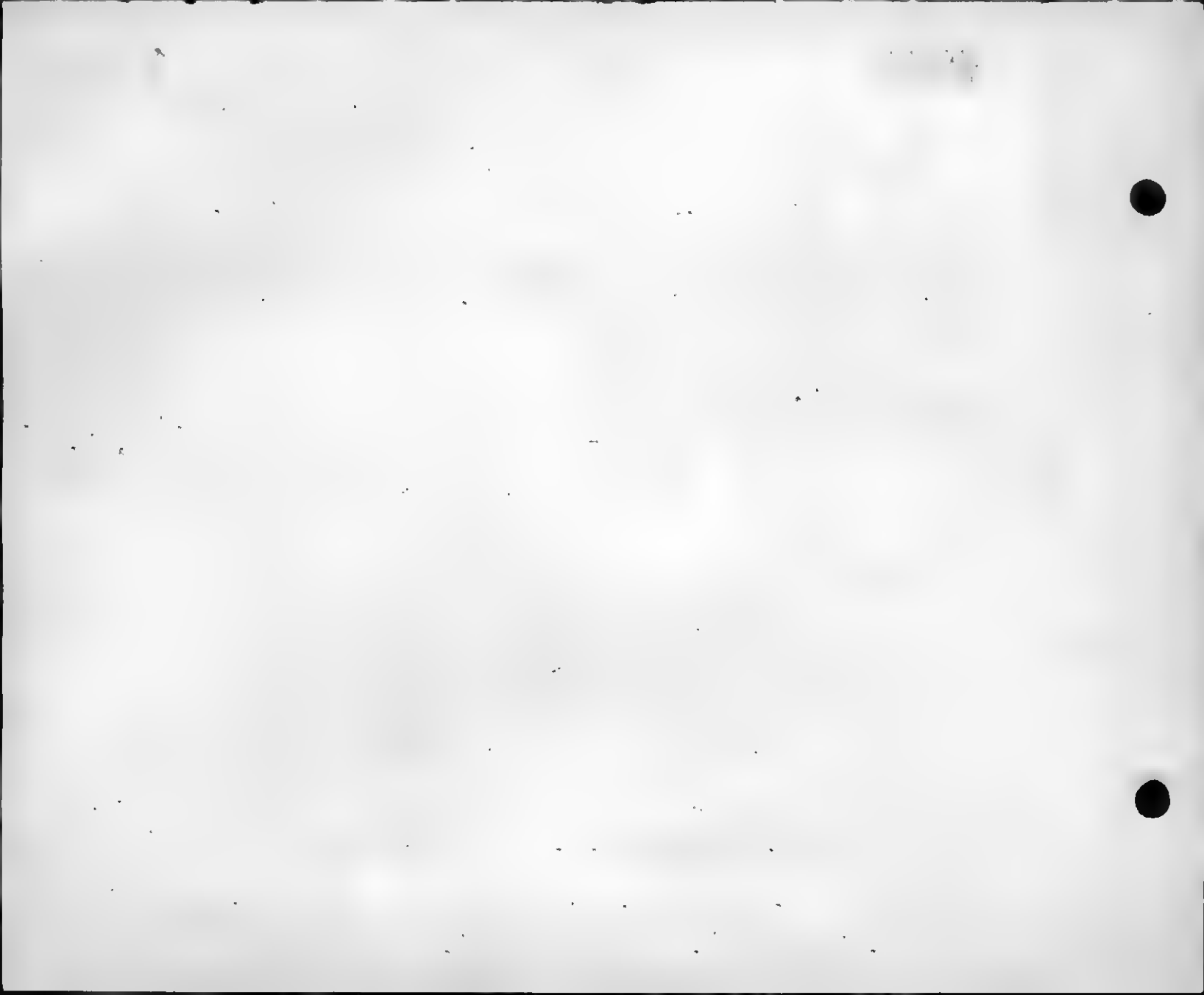


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6817 Prince Georges Ave., Takoma Park</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6817 Prince Georges Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>JEAN F. LAMBERT</u> 4. DATE OF DEATH <u>December 11 1965</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 8, 1907</u> 9. AGE (in years last birthday) <u>78 yrs.</u> IF UNDER 1 YEAR: Months <u>78</u> Days <u>11</u> Hours <u>19</u> Min. <u>65</u> | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>William Jantzen</u> 14. MOTHER'S MAIDEN NAME <u>Janet Todd</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>332-185-841</u> 17. INFORMANT <u>Miss Margaret Lambert, Takoma Park, Md.</u> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spindle cell carcinoma of thyroid</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> 20c. TIME OF INJURY Month, Day, Year <u>none</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 24, 1965</u> to <u>Dec 11, 1965</u>, that (I) last saw the deceased alive on <u>Dec 4, 1965</u>, and that death occurred at <u>12:11 PM</u>, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Leo J. Schildhaus</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/11/65</u> 22c. PHYSICIAN'S NAME (Type) <u>Leo J. Schildhaus, M.D.</u> 22d. ADDRESS <u>6101 NEW HAMPSHIRE AVENUE WASH DC</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>Dec. 15, 1965</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u> 23d. LOCATION (City, town or county) <u>Cook County, Illinois</u> (State) _____ | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Walter E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>DEC 15 1965</u> | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

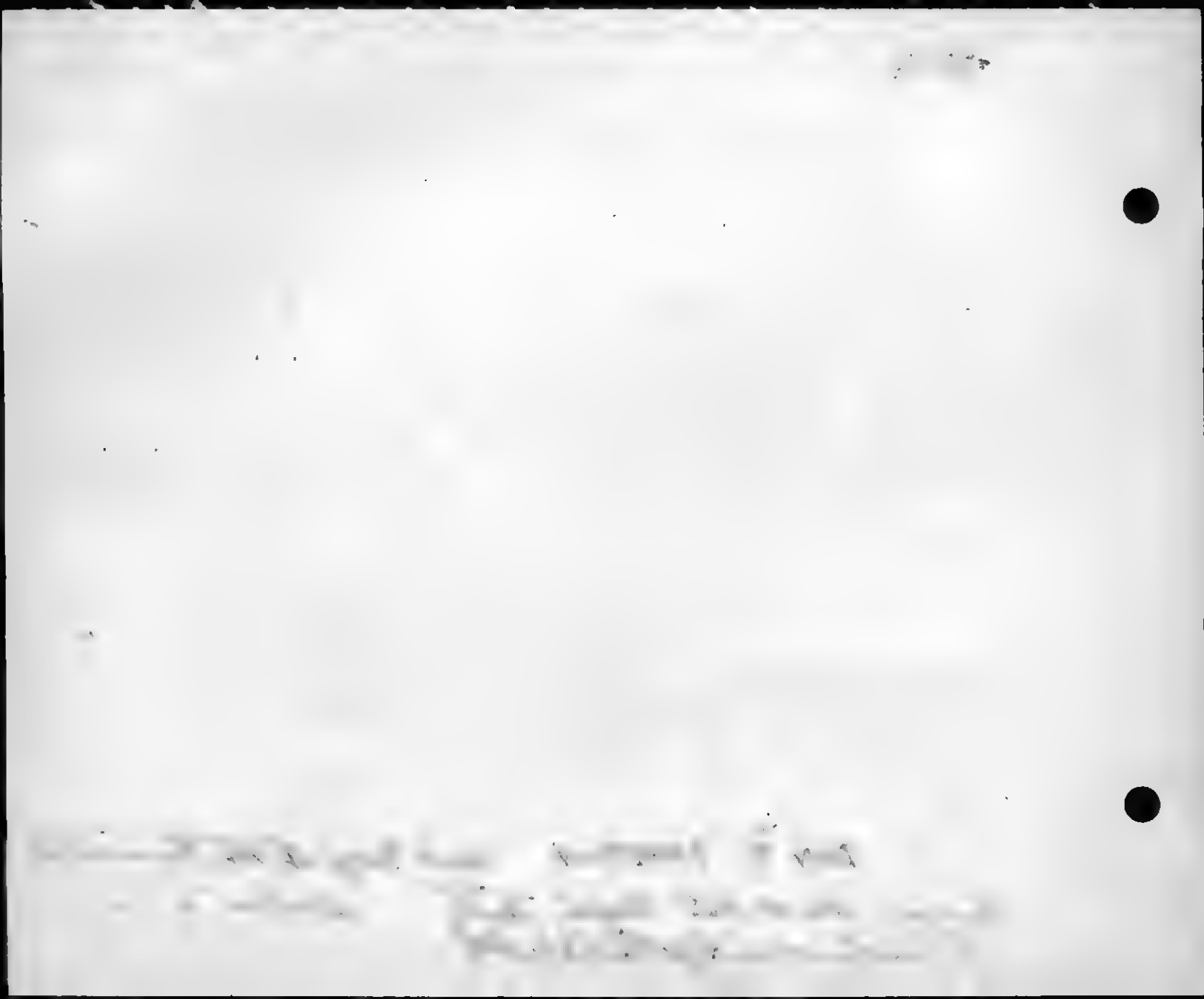
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 37 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 3607 Jefferson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Frank Lanier | | | 4. DATE OF DEATH Month December Day 20 Year 1965 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-12-02 | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10b. KIND OF BUSINESS OR INDUSTRY linotype | | 11. BIRTHPLACE (County & State, or foreign country) Davidson Co N. C. | | | |
| 13. FATHER'S NAME Umey Lanier | | | 14. MOTHER'S MAIDEN NAME Palie Smith | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 579 07 3047 | | 17. INFORMANT Hospital records Address Cheverly, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 101X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma stomach (c) Pulmonary edema | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1965 , to Dec 20, 1965 that (I) (we) last saw the deceased alive on Dec 20, 1965 , and that death occurred at 2:15 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Don B. Cameron | | | 22b. DATE SIGNED 12-20-65 | | | | |
| 22c. PHYSICIAN'S NAME (Type) DON B. CAMERON | | | 22d. ADDRESS 3503 Perry St Mt. Rainier Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 23, 1965 | 23c. NAME OF CEMETERY OR CREMATORY Chapel Hill | 23d. LOCATION (City, town or county) (State) Clinton N. C. | | | | |
| 24. FUNERAL DIRECTOR F. Esch's Sons Hyattsville Md | | | 25a. REC'D BY REGISTRAR DEC 27 1965 | | | | |
| | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

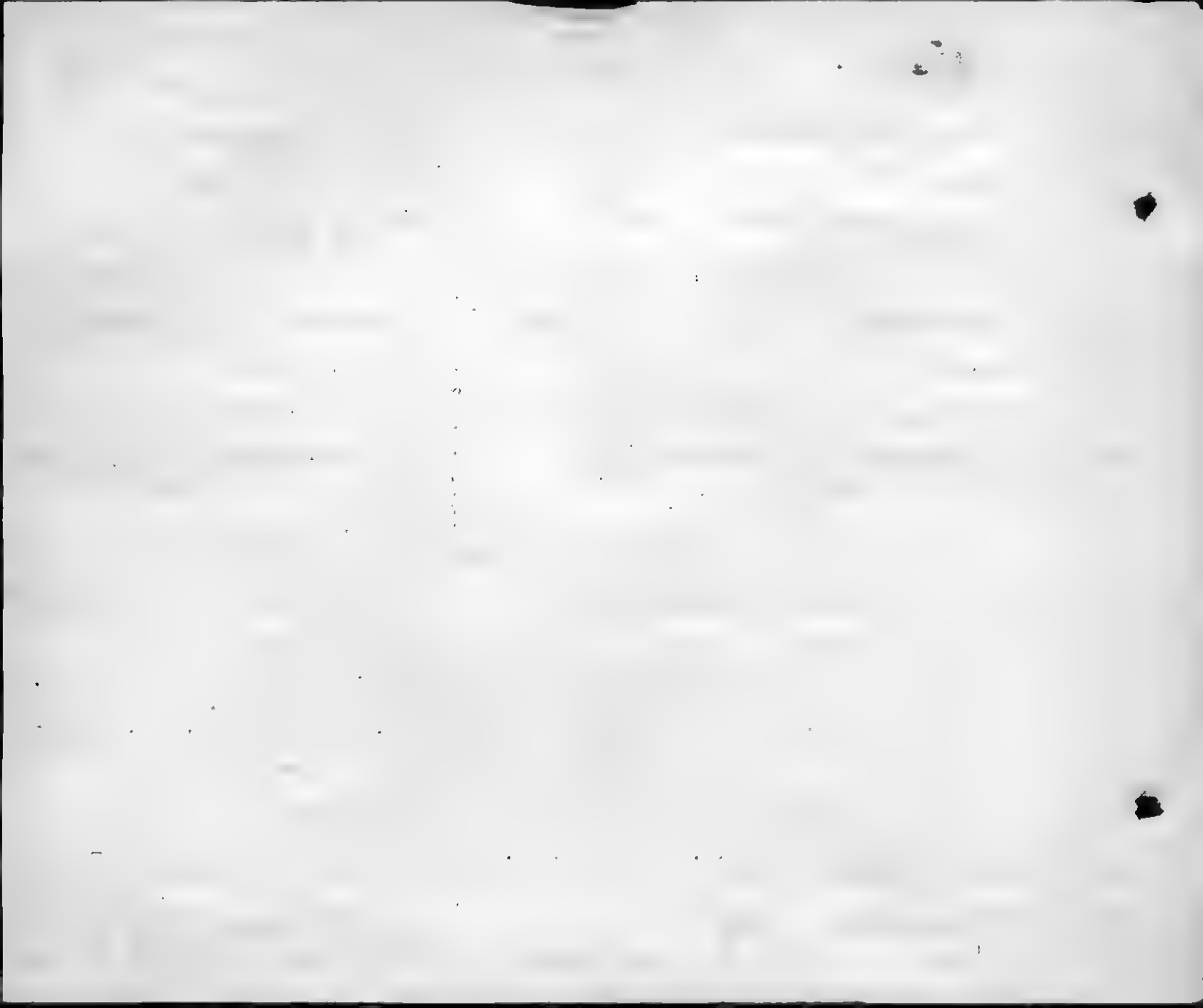


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-37. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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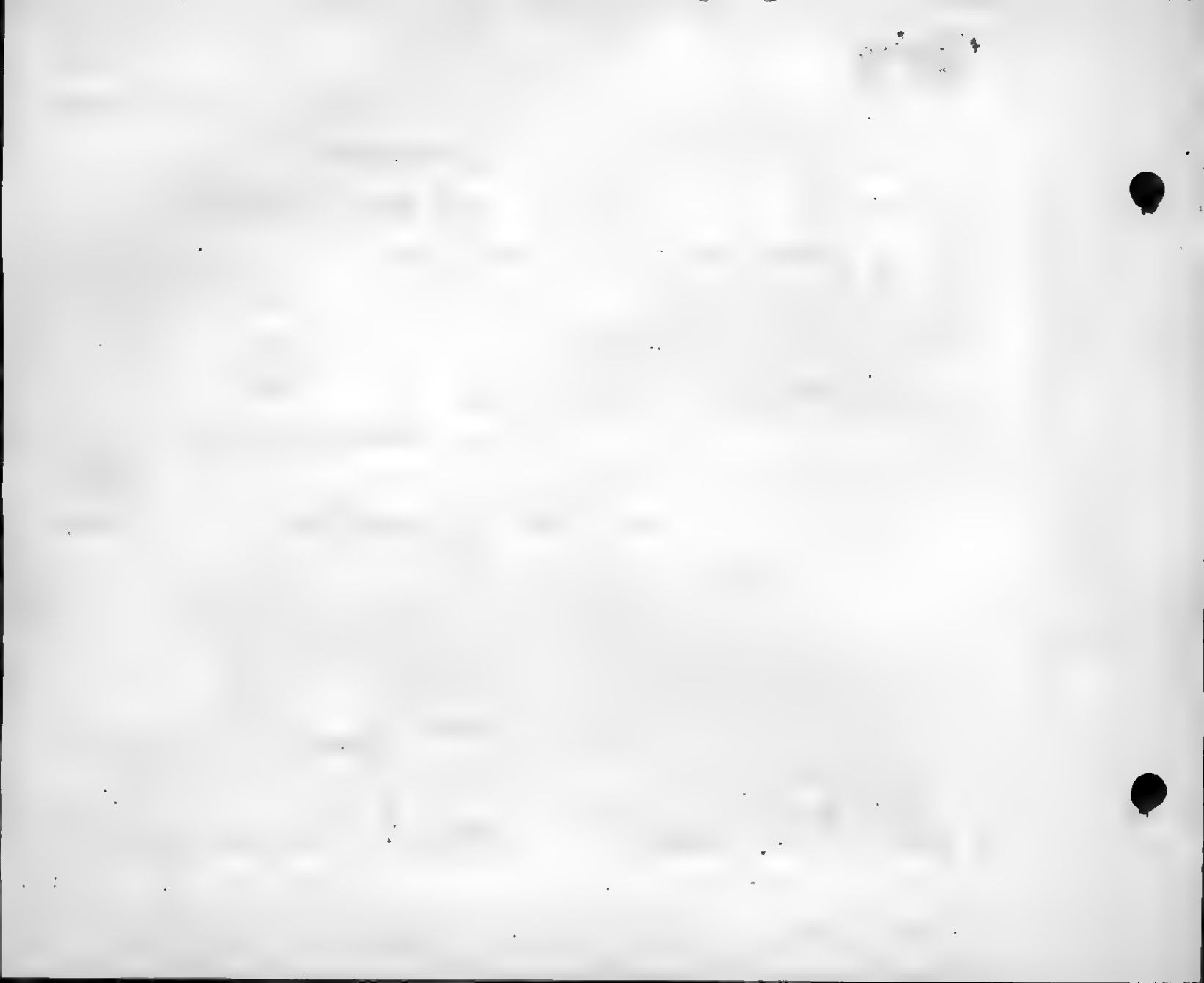
| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY in 1b <u>1 1/2</u> hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andrews Air Force Base Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Rtl. Box 8-10</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ardena Frances Leake</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-9-1937</u> 9. AGE (in years last birthday) <u>27</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>2</u> Hours <u>19</u> Min. <u>65</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u> 11. BIRTHPLACE (State or foreign country) <u>Texas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | | | | | |
| 13. FATHER'S NAME <u>David Elmore Minen</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>N/A.</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>Husband</u> Address <u>Same as #2</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Leitha Leo Acordmnd</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>From bilateral pneumothorax</u> (b) <u>and laceration of liver</u> DUE TO <u>And retroperitoneal hemorrhage</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Driver, thrown out of car, which ran off road and overturned.</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 12-2-1965</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wine, Md.</u> (City or town) (County) (State) 20f. (City or town) <u>Wine, Md.</u> (County) (State) 20g. (City or town) <u>Cedarville Road, 13 miles off Rt. 301, Brandy-</u> | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>John Nehoe</u> M.D. DATE SIGNED <u>12-3-65</u> EXAMINER'S NAME (Type) <u>John Nehoe, M.D. Riverdale, Md.</u> Address (Street, city, town, or county) _____ | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/7/65</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Nevilles Chapel</u> 22d. LOCATION (City, town, or county) (State) <u>Mt. Pleasant, Tex.</u> | | | | 23. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u> ADDRESS <u>517-11th St. SE Wash, D.C.</u> 24a. REC'D BY REGISTRAR <u>DEC 6 1965</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Lanham</i> c. LENGTH OF STAY IN 1b <i>64X-2</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>New York</i> b. COUNTY <i>New York</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>New York</i> d. STREET ADDRESS <i>533 West 113th Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Margaret Osborn Lounsbury</i> First Middle Last 5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 4. DATE OF DEATH <i>Dec 16 1965</i> Month Day Year 8. DATE OF BIRTH <i>4/25/1896</i> 9. AGE (In years last birthday) <i>69</i> yrs. IF UNDER 1 YEAR Months <i>9</i> Days <i>9</i> IF UNDER 24 HRS. Hours <i>9</i> Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Iowa</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | 13. FATHER'S NAME <i>Herbert Osborn</i> 14. MOTHER'S MAIDEN NAME <i>Sales</i> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> 16. SOCIAL SECURITY NO. 17. INFORMANT <i>Myron H. Lounsbury same as #2 (husband)</i> Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> DUE TO (b) <i>Arterio sclerosis generalized</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>5 months</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>11/21/65</i> , 19 <i>65</i> to <i>12/16</i> , 19 <i>65</i> that (I) (we) last saw the deceased alive on <i>12/16</i> , 19 <i>65</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above. | | | | | | | | | | | | 22a. SIGNATURE <i>John A. Hevitsky</i> 22b. DATE SIGNED <i>12/16/65</i> 22c. PHYSICIAN'S NAME (Typed) <i>John A. Hevitsky</i> 22d. ADDRESS <i>91st Garfield Rd, Lanham, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>12/18/65</i> 23c. NAME OF CEMETERY OR OREMATORY <i>Mt. Hope</i> 23d. LOCATION (City, town or county) (State) <i>Westchester Co. N. Y.</i> | | | | 25a. REC'D BY REGISTRAR <i>DEC 20 1965</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

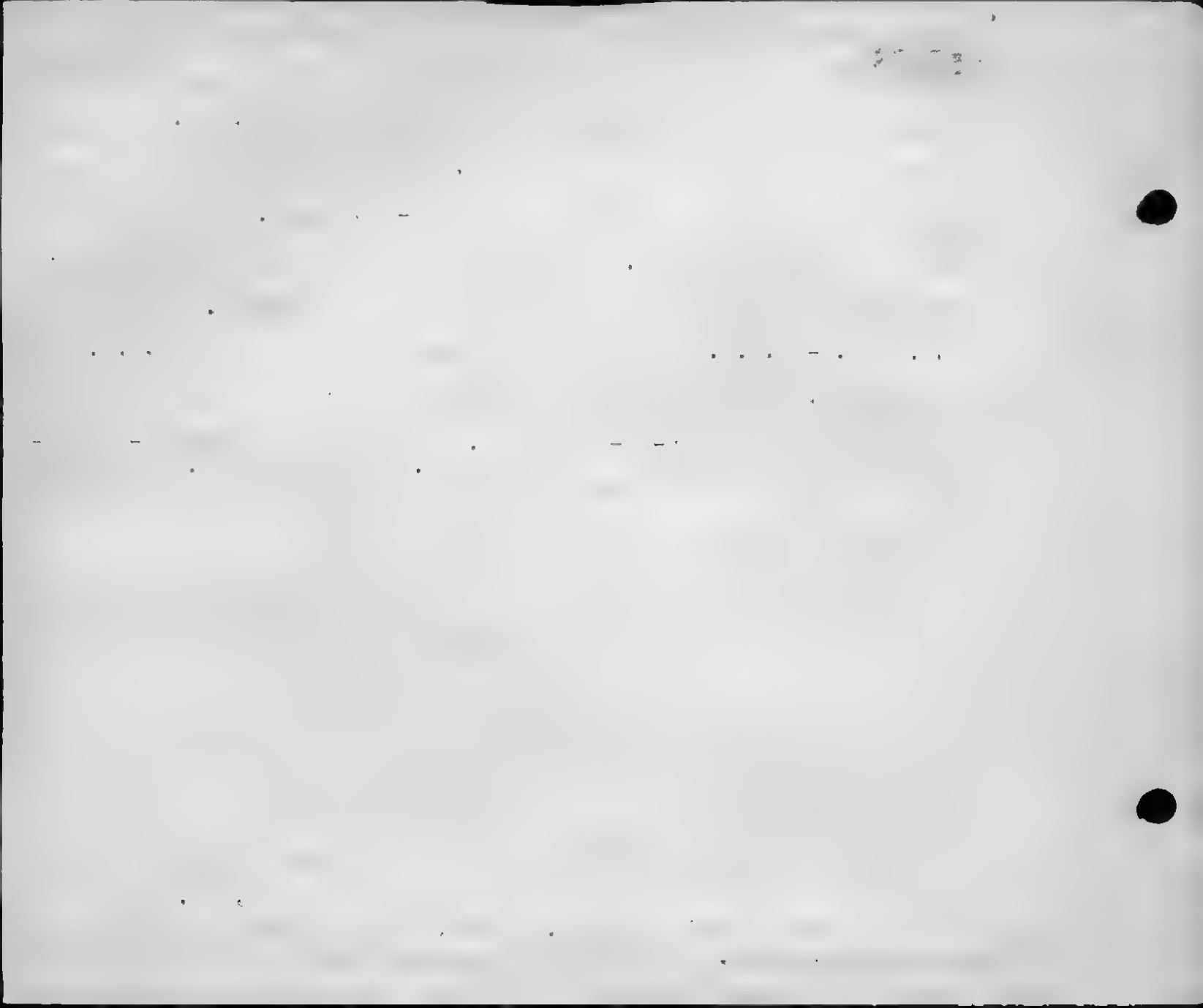
CERTIFICATE OF DEATH

16863

1245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|--|-----------------------------------------------------------------------------|--|-----------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Huntseat</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Madison Manor Nursing Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>E. Riverdale</u> d. STREET ADDRESS <u>5424 - 56th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ada V. Lusby</u> | | 4. DATE OF DEATH <u>Dec. 21, 1965</u> | | 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/4/196</u> | | 9. AGE (In years last birthday) <u>69 yrs.</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt. - G.P.O.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James M. Green</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Gordon</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>578-58-9376</u> | | | | 17. INFORMANT <u>Mrs. Dorothy Couperthwaite - 8438 - 57th Ave. Berwyn Hts., Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 441X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1963</u> to <u>12/21, 1965</u> , that (I) (we) last saw the deceased alive on <u>12/18, 1965</u> , and that death occurred <u>11 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Hugh T. M.D.</u> | | | | | | | | 22b. DATE SIGNED <u>12/22/65</u> | | | | 22c. PHYSICIAN'S NAME (Type) <u>Hugh T. M.D.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>12/24/65</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u> | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's</u> ADDRESS <u>Mt. Rainier, Maryland</u> | | | | | | | | 25a. REC'D BY REGISTRAR <u>DEC 28 1965</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |



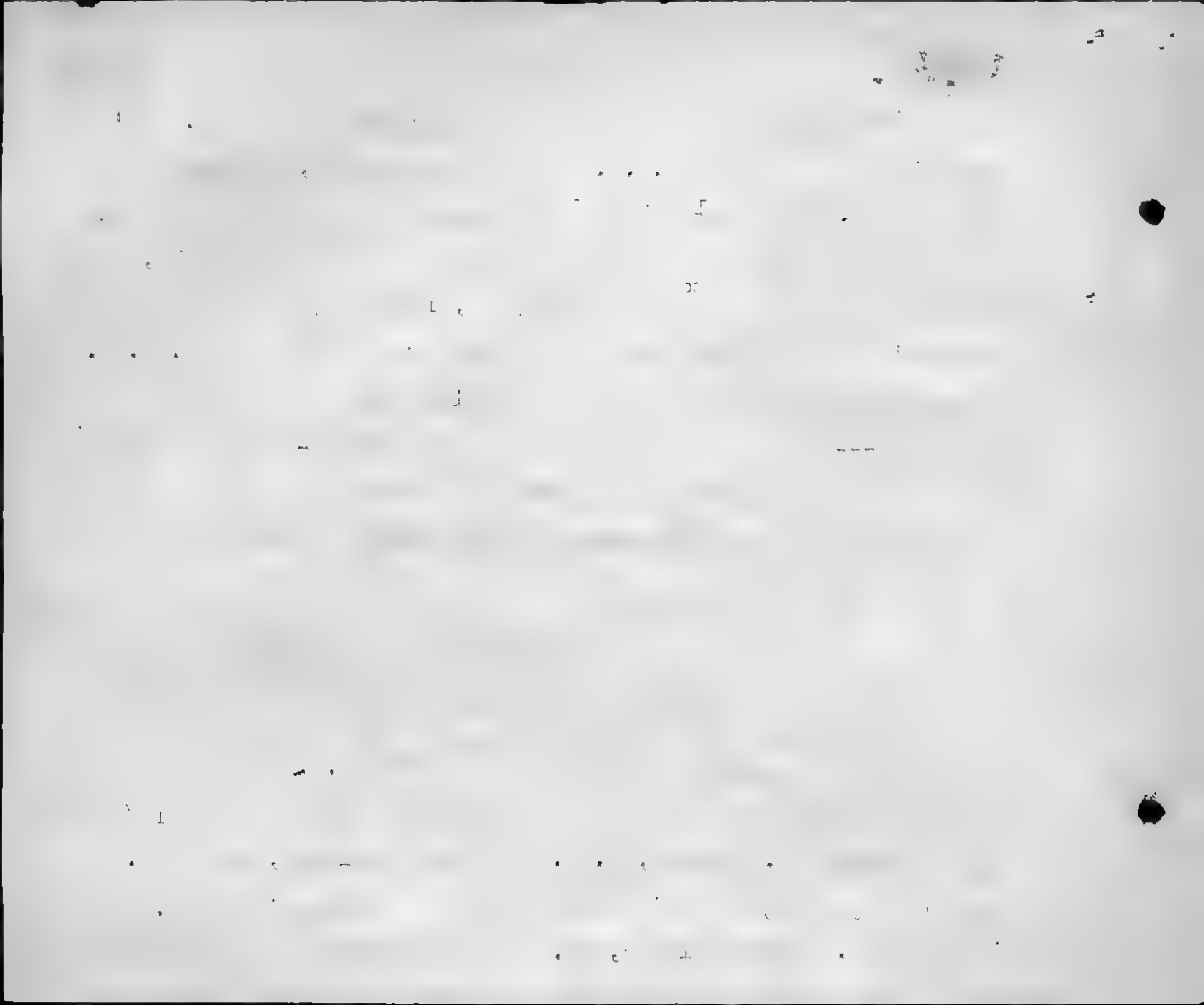
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16864 CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geor's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland d. STREET ADDRESS Box 1739 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Maude Parrine Lusby | | 4. DATE OF DEATH Month December Day 12 Year 1965 | |
| 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 26, 1889 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James Henry Denton | | 14. MOTHER'S MAIDEN NAME Louisa Wood | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. --- 17. INFORMANT Edward Henry Lusby- Address Same as Item #2 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. 19 p.m. 12:20 P.M. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Dec 1965 to 12 Dec 1965 , that (I) (we) last saw the deceased alive on 12 Dec 1965 , and that death occurred at 12:20 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] M.D. Robert B. Sasscer, M. D. | | 22b. DATE SIGNED 12/12/65 | |
| 22c. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D. | | 22d. ADDRESS Upper Marlboro, Maryland. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/15/65 | |
| 23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery | | 23d. LOCATION (City, town or county) (State) Forestville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md. | | 25a. REC'D BY REGISTRAR DEC 27 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

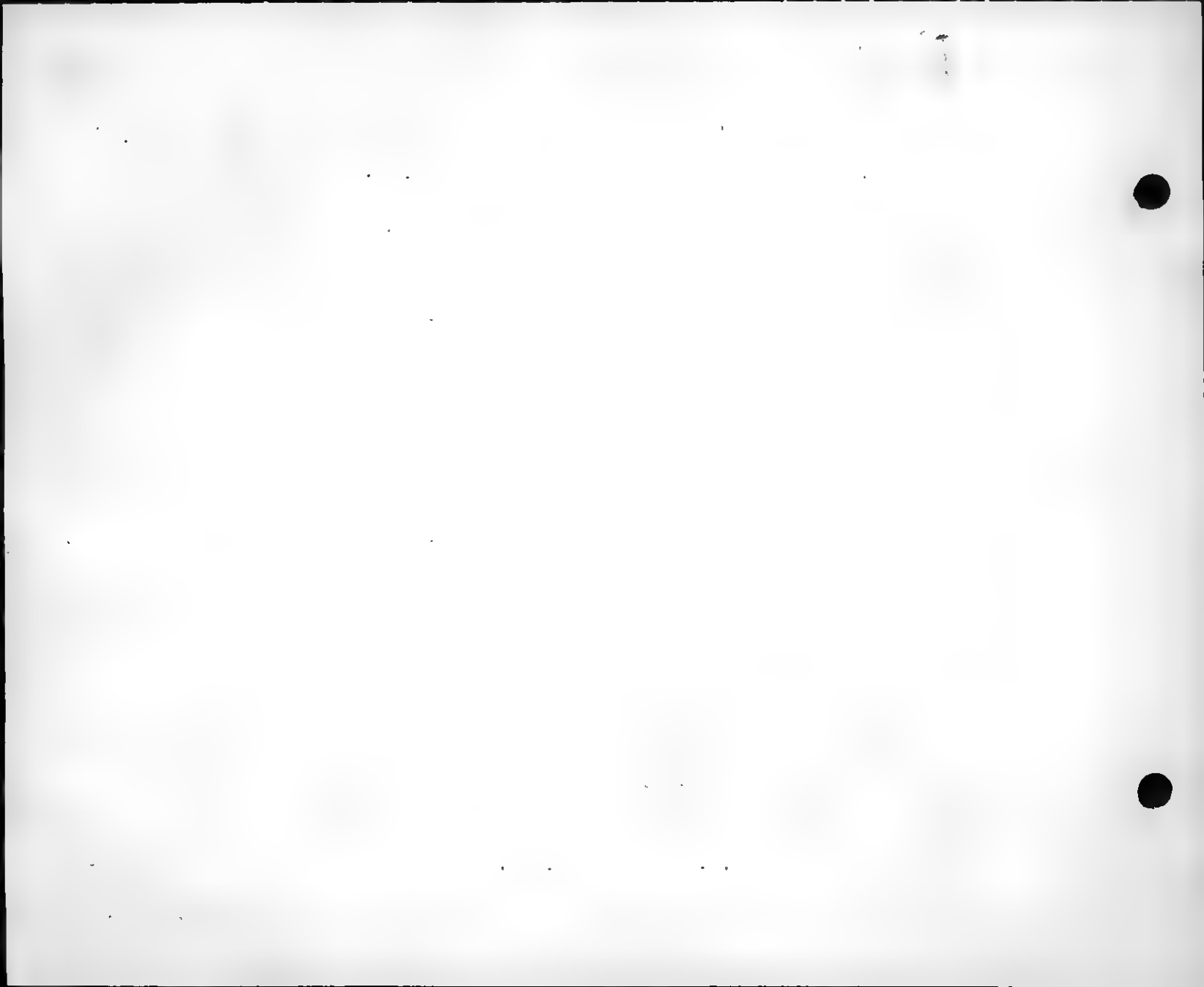
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0247

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| 1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c LENGTH OF STAY IN 1b <u>DOA</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | d STREET ADDRESS <u>4255 Dowerhouse Road</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>P</u> Last <u>Marshall</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1965</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>11-23-1893</u> |
| 9 AGE (in years last birthday) <u>72</u> yrs | | F UNDER YEAR Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Janitor</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>William Marshall</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth ???</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT <u>Raymond Marshall</u> | | Address <u>Marlboro, Box 4255 Maryland</u> | |
| 18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 10 yrs.</u> | | | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) <u>12-29-65</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>1/3/65</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u> |
| 24 FUNERAL DIRECTOR <u>Stewart Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>JAN 4 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u> |



1

FOR STATE HEALTH DEPT.

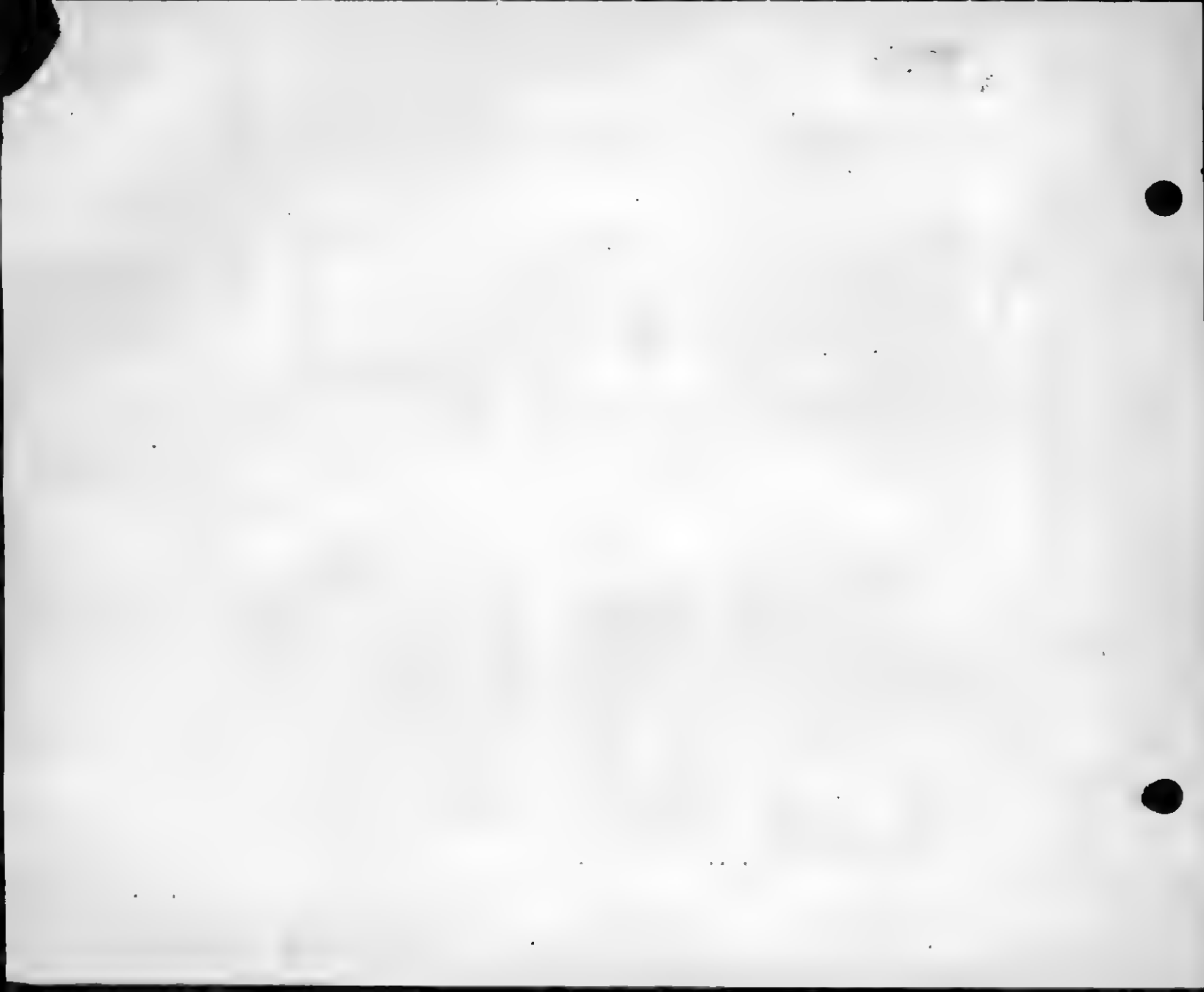
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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3500 4-64

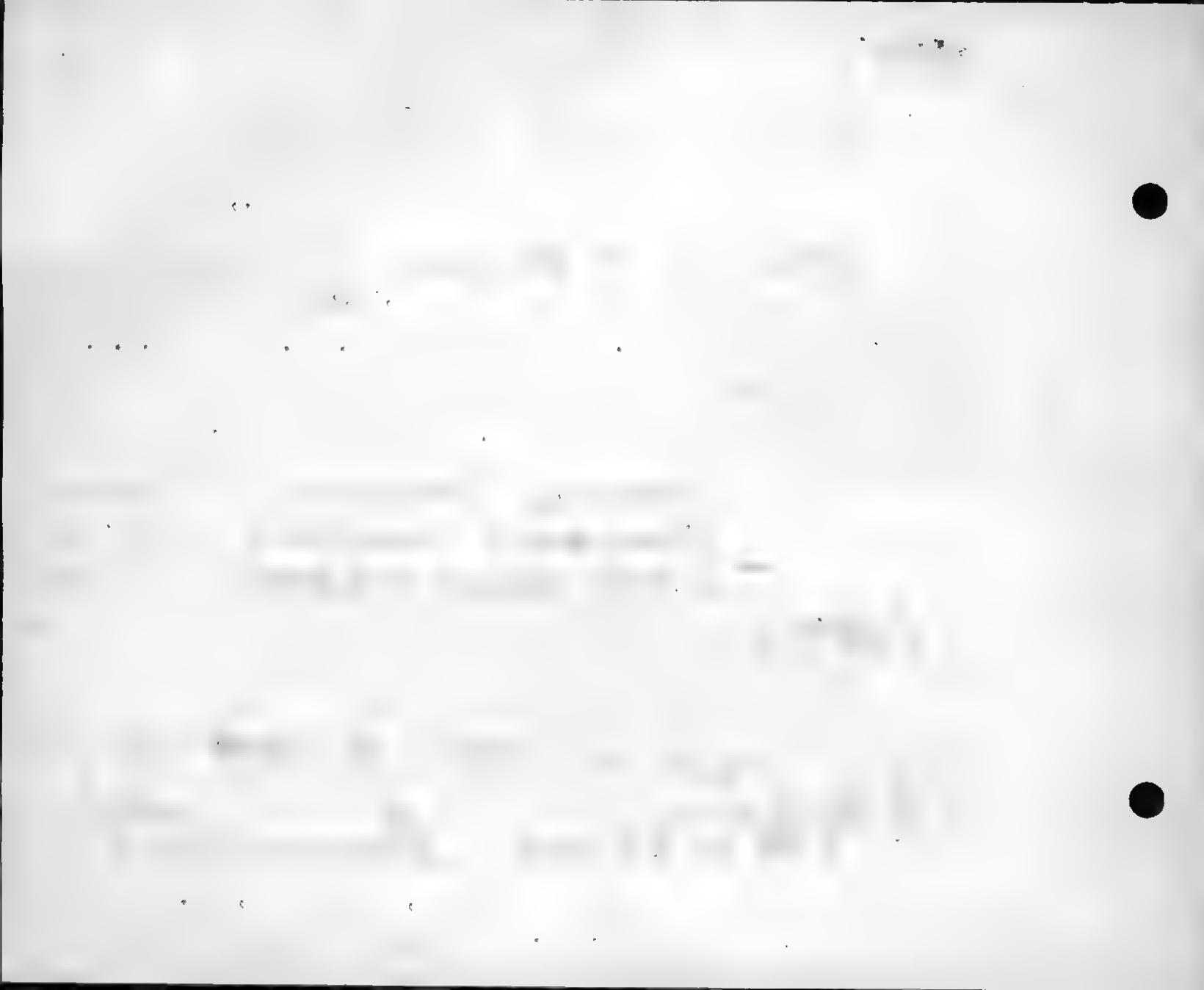
| Items 188-21 Film G372 MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 16866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum d. STREET ADDRESS 5801 Sargent Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Frances Middle Isabelle Last Maske | | | 4. DATE OF DEATH Month 12 Day 10 Year 1965 | | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-14-11 | | 9. AGE (In years last birthday) 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY U S Government | | 11. BIRTHPLACE (State or foreign country) Delaware | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME James Brogan | | | | | 14. MOTHER'S MAIDEN NAME Isabelle Gardner | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 577 05 5373 | | 17. INFORMANT Carl V Maske | | | Address Chillum, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 3120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Kehoe</i> | | EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 12-11-65 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 14, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 23d. LOCATION (City, town or county) (State) Washington D. C. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | | 24a. REC'D BY REGISTRAR DEC 16 1965 | | 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|--------------------------------------------------------------------------------------------|--|---------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| 16887 Items 8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH Item #4 Film #3322 12/24/65 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | b. COUNTY Prince George | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | | c. LENGTH OF STAY IN 1b D O A | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial | | | | | | | | d. STREET ADDRESS 820 West Street., | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last BERNARD T. MATTHEWS | | | | 4. DATE OF DEATH Month Day Year 12 11 1965 | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 16, 1898 | | 9. AGE (In years, months, days) 67 yrs. | | 10. FINDER 1 YEAR Months Days Hours Min. | | 11. FINDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | | | 10b. KIND OF BUSINESS OR INDUSTRY Govt. | | | | 11. BIRTHPLACE (County & State, or foreign country) Howard Co. Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Matthews | | | | | | | | 14. MOTHER'S MAIDEN NAME Laura Hebron | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | | 17. INFORMANT Mrs. Margaret Matthews: Item # 2 | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY THROMBOSIS DUE TO (b) CORONARY SCLEROSIS DUE TO (c) CARCINOMA R. LUNG INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 yrs 1 yr. | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/10, 1961, to 12/14, 1965, that (I) (we) last saw the deceased alive on 12/10, 1965, and that death occurred at M, from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE J M Warren | | | | 22b. DATE SIGNED 12/13/65 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) J M WARREN | | | | 22d. ADDRESS Laurel Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 12-16-65 | | | | 23c. NAME OF CEMETERY OR CREMATORY Carver Memorial, | | | | 23d. LOCATION (City, town or county) (State) Laurel, Md. | |
| 24. FUNERAL DIRECTOR Robert L. Sworden | | | | | | | | 25a. REC'D BY REGISTRAR DEC 20 1965 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

16868

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------------------------------------|--|-----------------------------------------------|--|-----------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 hr. 50 mins d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9014 Rhode Island Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Matthew RAYMOND McIntyre | | 4. DATE OF DEATH December 7 1965 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 6/3/01 | | 9. AGE (in years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY District of Columbia | | | | 11. BIRTHPLACE (County & State, or foreign country) District of Columbia | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME John H. McIntyre | | | | 14. MOTHER'S MAIDEN NAME Sola Anna Reynolds | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. NONE | | | | 17. INFORMANT MISS RUTH C. McINTYRE Address SAME AS #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO crown pneumonia (b) myocardial infarction DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1965 to Dec 7, 1965 that (I) (we) last saw the deceased alive on 12/7, 1965 and that death occurred at 4:10 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Dr. Leon R. Levitsky | | | | | | | | | | | | 22b. DATE SIGNED 12/7/65 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Leon R. Levitsky | | | | | | | | | | | | 22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 12-11-1965 | | | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | | | | 23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers, Co. Riverdale, Md | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DEC 9 1965 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

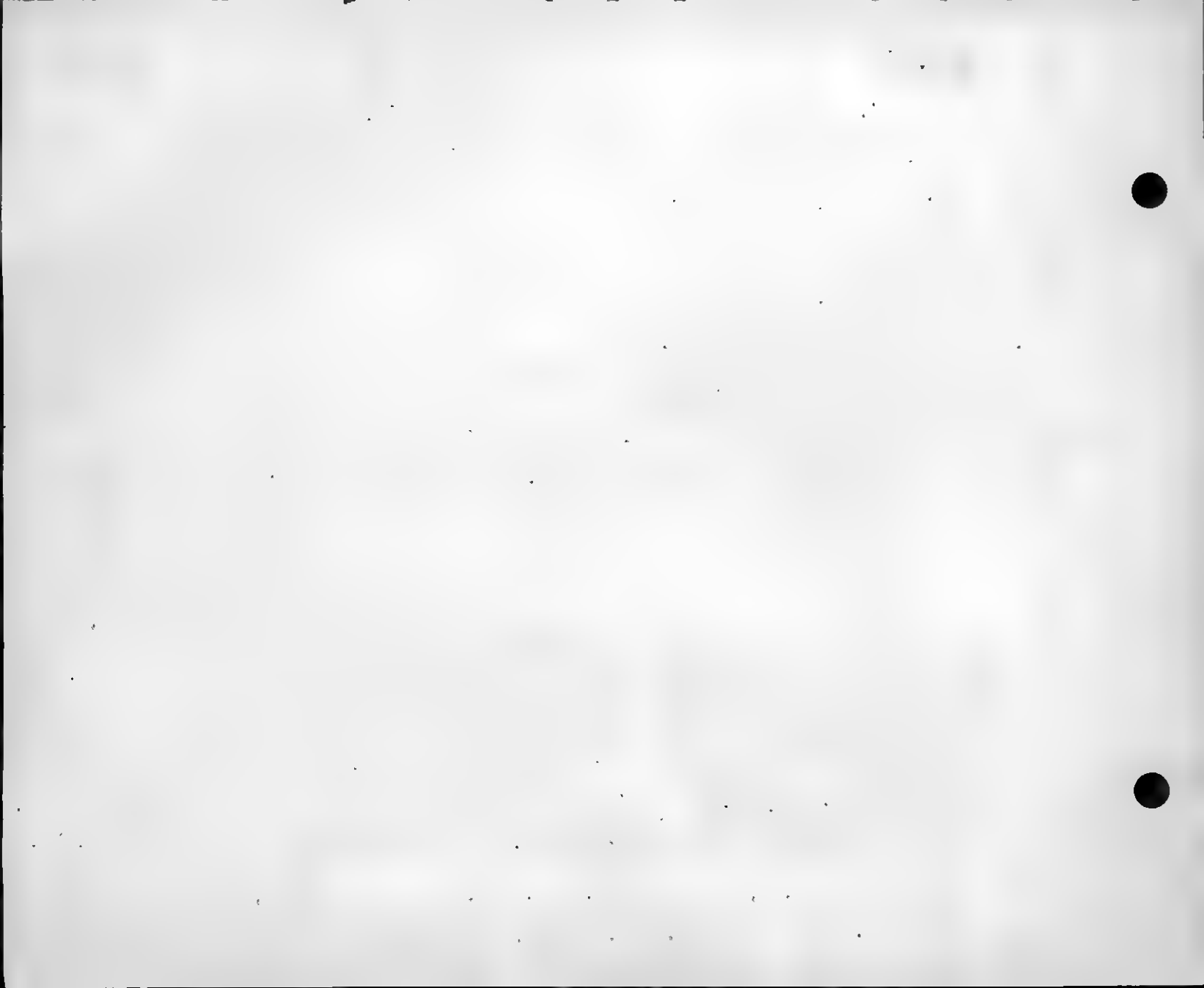


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY P.G.C. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY PG | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 2 days | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont, Md. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General | | | | d. STREET ADDRESS 727 51st Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First: Baby Boy Middle: McNeill Last: | | | | 4. DATE OF DEATH Month: 12 Day: 16 Year: 1965 | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE C. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12 2 65 | | 9. AGE (In years last birthday) yrs. 2 | | IF UNDER 1 YEAR Months: Days: Hours: Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (County & State, or foreign country) Cheverly, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME JOSEPH YOUNG | | | | | | 14. MOTHER'S MAIDEN NAME FRANCES McNeill | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Hospit 1 Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis (cause undetermined) (b) (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/8/65, 19 to 12/10, 1965 that (I) (we) last saw the deceased alive on 12/10, 1965, and that death occurred at 10:50P, from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Thomas A. Christensen M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/13/65 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D. | | | | | | 22d. ADDRESS 6905 Baltimore Ave. College Park, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF Dec. 17, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park Cem | | | | 23d. LOCATION (City, town or county) (State) LANDOVER, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland | | | | | | 25a. REC'D BY REGISTRAR DEC 20 1965 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

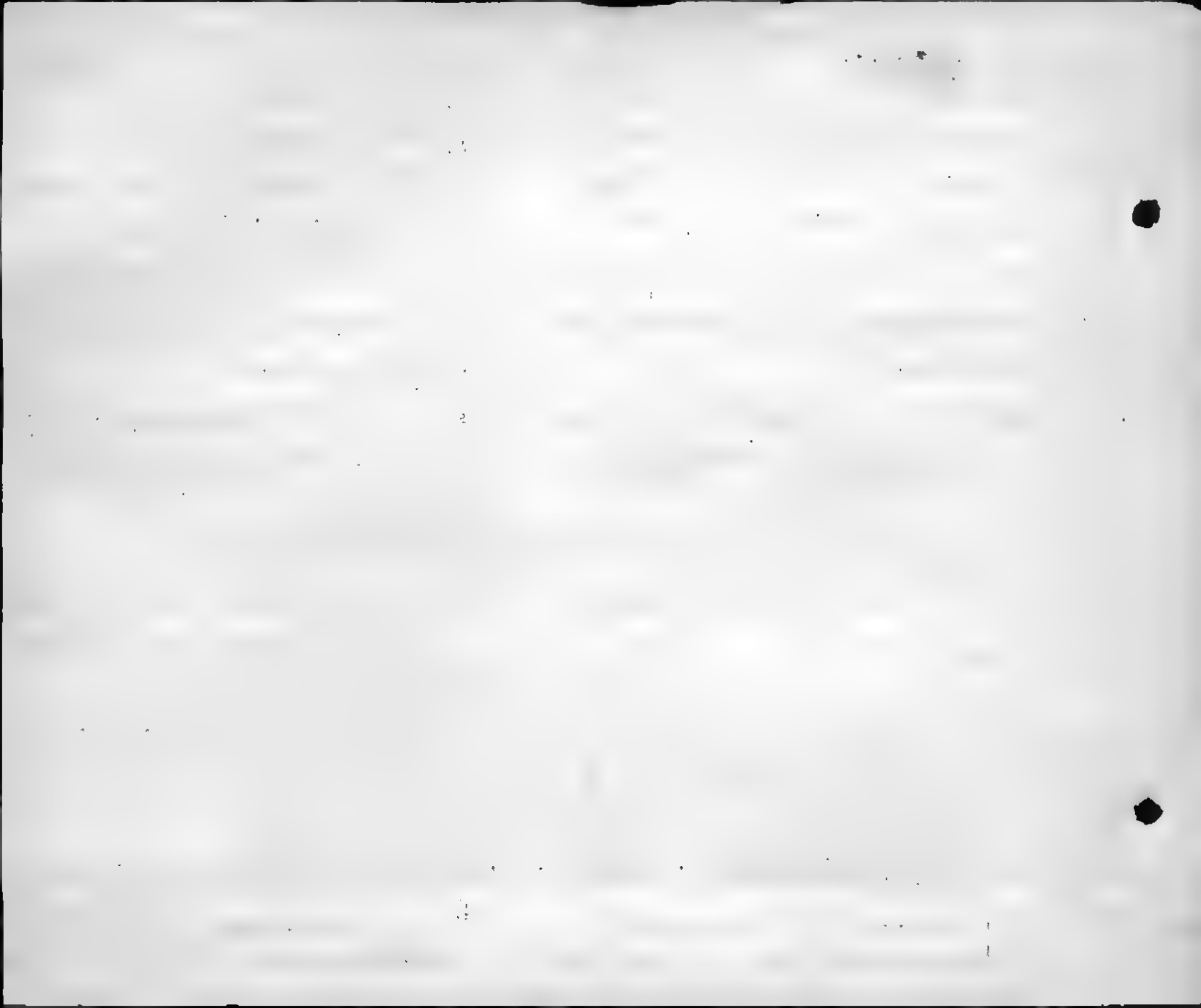
14825



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Items 18-21 Film G372 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andrews Air Force Base Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> d. STREET ADDRESS <u>4425 Arnold Road, Apt. T-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth Mary McQuaide</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1965</u> | | | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>23 June 1917</u> 9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Personnel</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> 11. BIRTHPLACE (State or foreign country) <u>Indiana</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Clarence G. McQuaide</u> 14. MOTHER'S MAIDEN NAME <u>Helen Mc Cune</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>***-****-****</u> 17. INFORMANT <u>Eleanor McQuaide</u> Address <u>3726 Conn. Ave, Wash, DC</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>From first and second degree burns of 90% of body surface</u> (c) <u>And acute alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathtub of hot water</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>abt. 5 p.m. 12/16/65</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Suitland Pr. Geo. Md.</u> | | (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-17-65</u> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | | 22b. DATE THEREOF <u>12/20/65</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | | | 22d. LOCATION (City, town, or county) <u>Suitland, Md.</u> (State) <u> </u> | |
| 23. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave, NW, Washington, D.C.</u> | | | | | | 24a. REC'D BY REGISTRAR <u>DEC 23 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 24c. REGISTRAR'S NAME <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Riverdale, Md. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges. | | | | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Riverdale, Md. | | | | | d. STREET ADDRESS 5417 56th Place | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Maurice Mc Sweeney | | | | | 4. DATE OF DEATH Month Dec Day 19 Year 19 65 | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct 16, 1888 | | 9. AGE (In years last birthday) 77 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Electrician | | 11. BIRTHPLACE (County & State, or foreign country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 13. FATHER'S NAME Daniel Mc Sweeney | | | | | 14. MOTHER'S MAIDEN NAME Nora Horan | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 051 07 7894 | | 17. INFORMANT Nora Mc Sweeney East Riverdale, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE</u> 5x11 DUE TO (b) <u>EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-340 30 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u>, 19<u>62</u> to <u>DEC 1</u>, 19<u>65</u>, and that death occurred at <u>8:30 AM</u>, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | | 22b. DATE SIGNED 12-20-65 | | | | |
| 22c. PHYSICIAN'S NAME (Type) RUTH | | | | | 22d. ADDRESS 5417 56th Place, East Riverdale, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 22, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION (City, town or county) (State) Wheaton, Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DEC 27 1965 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------|--------------------------------------------|
| 15872 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | | | | c. LENGTH OF STAY IN 1b MAYLAND | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel | | | | |
| | | | | | d. STREET ADDRESS 35 Ev-Mar Mobile Village | | | | |
| 3. NAME OF DECEASED (Type or print) First Evelyn Middle Rose Last Messenger | | | | | 4. DATE OF DEATH Month December Day 31, Year 19 65 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-17-21 | | 9. AGE (in years last birthday) 44 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clarence Reed | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Husband/Medical Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-28, 1965, to 12-31, 1965, that (I) (we) last saw the deceased alive on 12 30 1965, and that death occurred at 7:30 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE C. J. Hounmann | | | | | | | | 22b. DATE SIGNED 12-31-65 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. Hounmann, M. D. | | | | | | 22d. ADDRESS 4404 Queensbury Road, Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | 23b. DATE THEREOF 12/31/65 | | 23c. NAME OF CEMETERY OR CREMATORY Bartlett Funeral Home | | 23d. LOCATION (City, town or county) (State) Gaithersburg West Va. | | |
| 24. FUNERAL DIRECTOR 7. Haeckis 4739 Belt Ave, Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR JAN 5 1966 | | 25b. REGISTRAR'S SIGNATURE James J. George | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

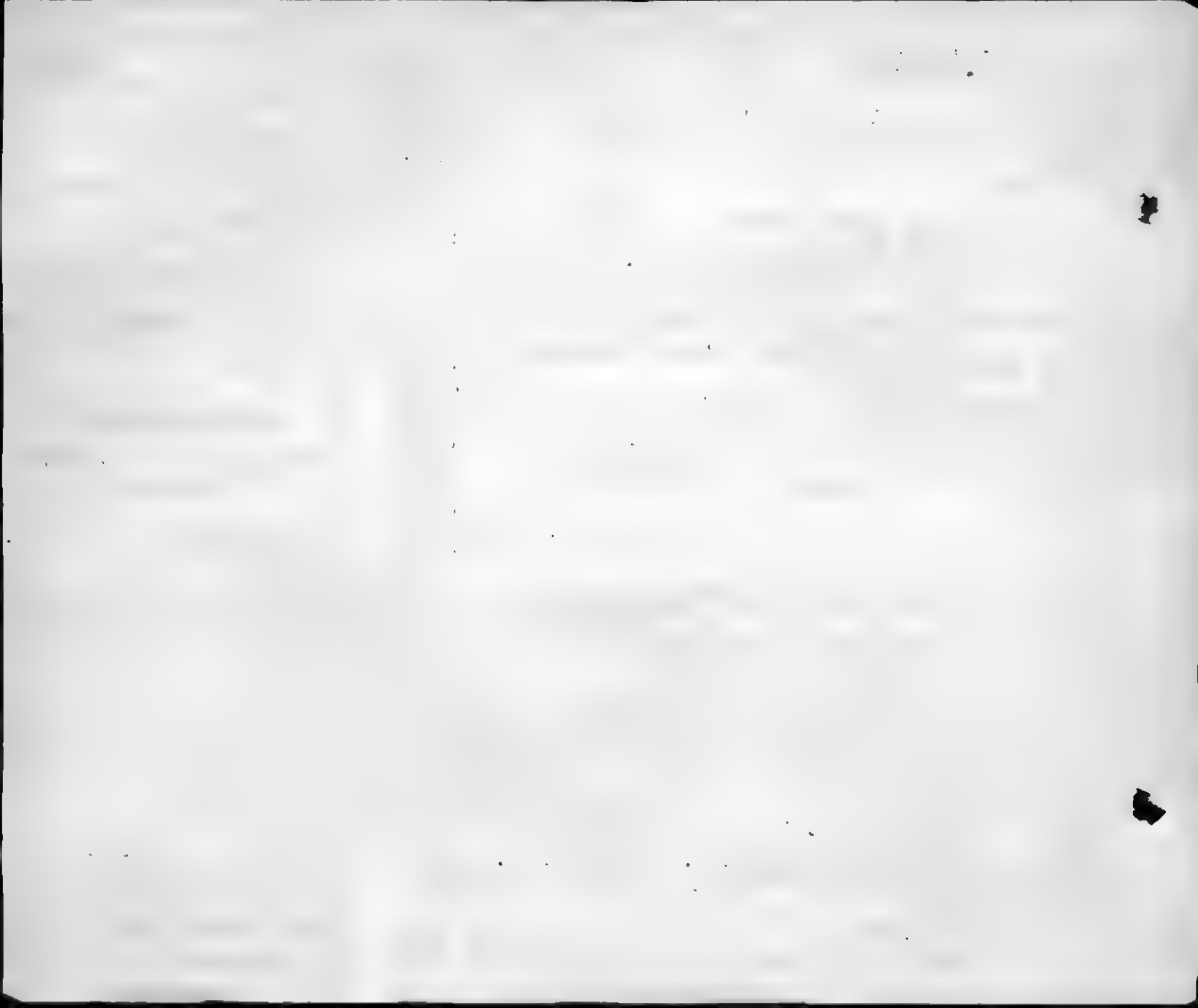
1
FOR STATE
HEALTH DEPT.

16873

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria | |
| c. LENGTH OF STAY IN ID DOA | | d. STREET ADDRESS 108 E. Braddock Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Middle Last James Nicholas Miles | 4. DATE OF DEATH Month Day Year 12 4 19 65 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 22 Dec., 1922 |
| 9. AGE (In years last birthday) 43 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Lineman | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Miles | | 14. MOTHER'S MAIDEN NAME Mary Gladys Barbour | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII and Korea | | 16. SOCIAL SECURITY NO. Mrs. Betty Miles | |
| 17. INFORMANT Address Alexandria, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Laceration of left ventricle DUE TO (c) Fracture of left 4th rib and sternum Trauma-auto accident | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off road and hit pole | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4:20 a.m. 12 4 19 65 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 495 nr st rt. 410, P.G., | | 20f. (City or town) (County) (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | 22. DATE SIGNED 12-4-65 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/7/1965 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 23d. LOCATION (City, town or county) (State) Arlington Co. Va. | |
| 24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home Alexandria, Va. | | 25a. REC'D BY REGISTRAR DEC 7 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16875

57

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md. c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home, Lanham, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Md. d. STREET ADDRESS 4218 - 37th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Minnie First Middle Last 4. DATE OF DEATH Dec. 29 1965 Month Day Year | | 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 18, 1879 9. AGE (in years last birthday) 86 yrs. IF UNDER 1 YEAR: Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (County & State, or foreign country) Texas | | | |
| 13. FATHER'S NAME Lawrence Jones | | 14. MOTHER'S MAIDEN NAME Mollie Beard | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 422-12-1728 | | 17. INFORMANT Mr. Hubert Morrison (above address) Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 392X Cerebral thrombosis (Son) DUE TO cerebral arteriosclerosis (b) DUE TO generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia INTERVAL BETWEEN ONSET AND DEATH | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 16, 1964, to Dec 29, 1965, that (I) (we) last saw the deceased alive on Dec 23, 1965, and that death occurred at 10 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Don B Cameron M.D. 22c. PHYSICIAN'S NAME (Type) DON B CAMERON | | | | 22b. DATE SIGNED 12-29-65 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS PERRY ST. MT. RAINIER MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF 12/31/65 | | 23c. NAME OF CEMETERY OR CREMATORY Live-Oak Cemetery | | | |
| 24. FUNERAL DIRECTOR Home Inc. | | 23d. LOCATION (City, town or county) Crenshaw County, Ala. (State) | | 25a. REC'D BY REGISTRAR 4 1966 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 1/63

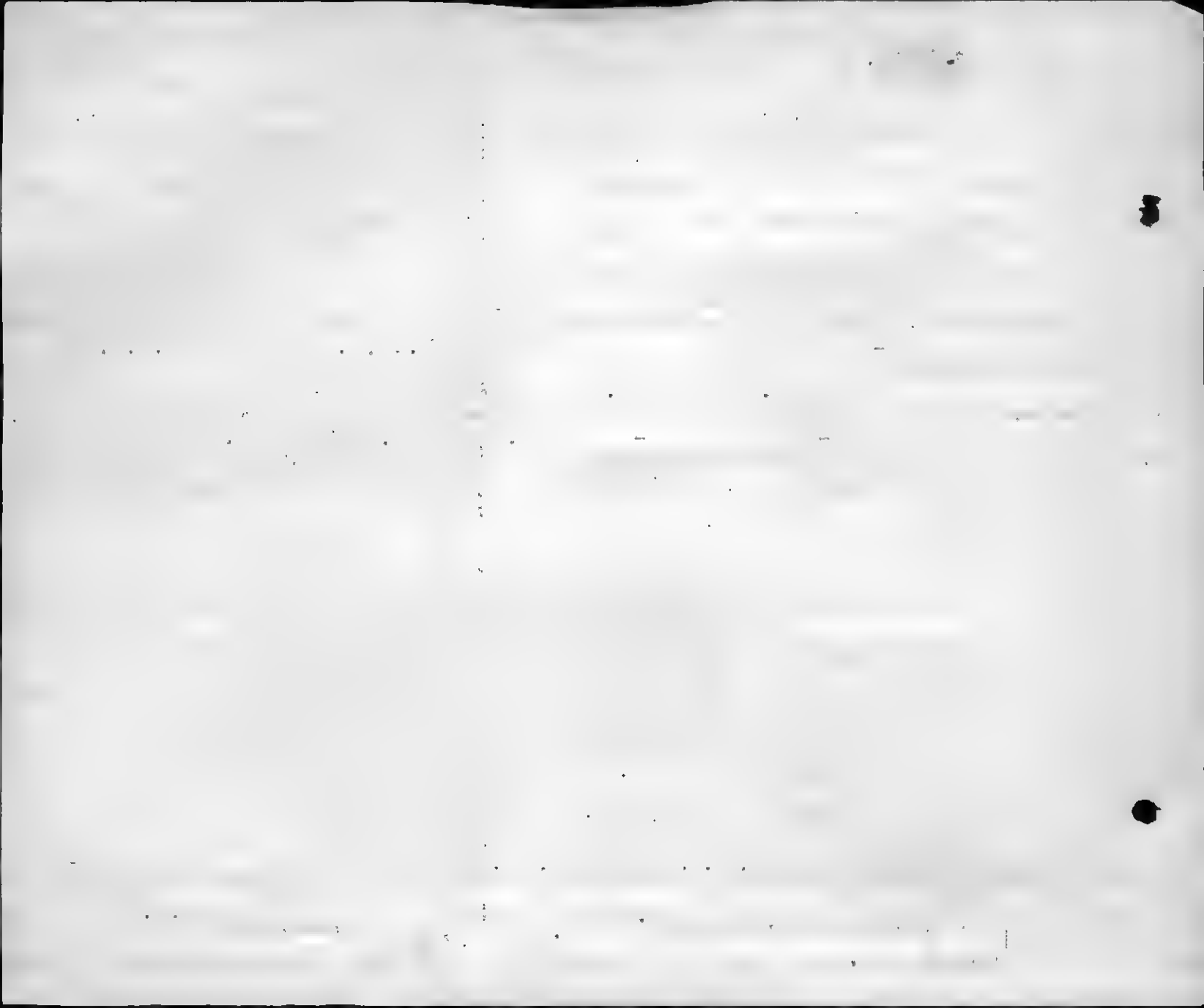
16876

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

258

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Prince George's g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville h. STREET ADDRESS 5907 Knollbrook Drive i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Richard Allen Murphy | | 4. DATE OF DEATH Month Day Year 12 26 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-27-1965 |
| 9. AGE (In years last birthday) 12 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. 1 1 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Wash., D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James F. Murphy Jr. | | 14. MOTHER'S MAIDEN NAME Bonnie Lee Redzensky | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Mr. James F. Murphy Jr. (above address) (Father) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John Kehoe, M.D. DATE SIGNED 12-27-65 EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12/28/65 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR Name Address Hoam Inc. Mt. Rainier, Maryland | | 24a. REC'D BY REGISTRAR DEC 29 1965 24b. REGISTRAR'S SIGNATURE Charles Judge | |

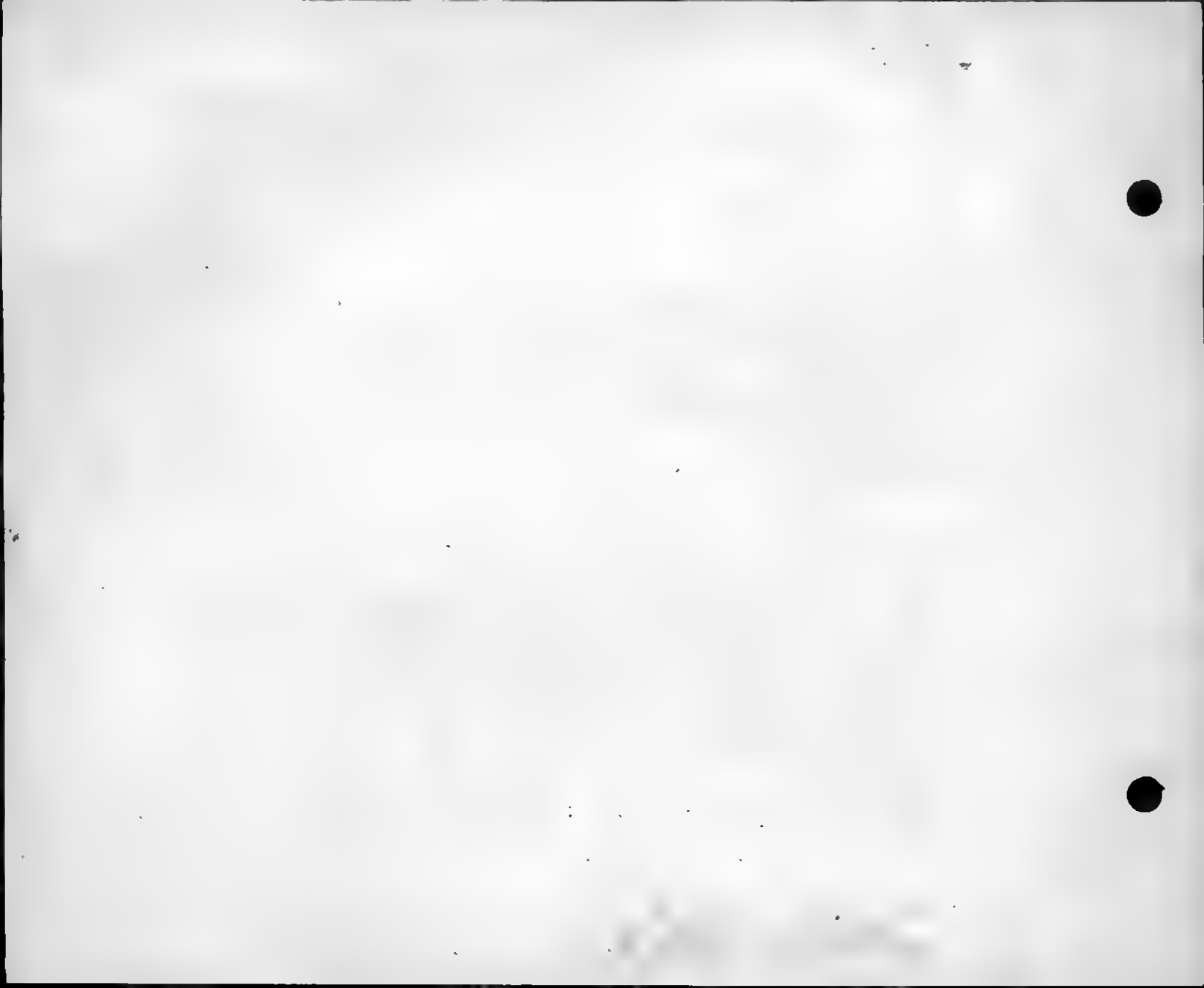
47



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 77X-3 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | | d. STREET ADDRESS 60 Maple St., N.E. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Evelyn Nesbitt | | | First Middle Last | | 4. DATE OF DEATH Dec. 20 19 65 | | Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 April 1895 | | 9. AGE (In years last birthday) 70 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Parris VanDyke Smalls | | | | | 14. MOTHER'S MAIDEN NAME Annie Singleton | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sadye Geneva Nesbitt - daughter, So. Car. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure Sec. To AHD 2. 4. 5. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 4:25 AM from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE Rosa L. Barlin M.D. | | | | | 22b. DATE SIGNED Dec. 20, 1965 | | | 22c. PHYSICIAN'S NAME (Type) Rosa L. Barlin, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | 23b. DATE THEREOF 12-21-65 | | 23c. NAME OF CEMETERY OR CREMATORY Fieldings Funeral Home | | 23d. LOCATION (City, town or county) (State) Charleston, South Carolina | | | |
| 24. FUNERAL DIRECTOR ALEX S. POPE | | | | | ADDRESS 414 15th St SE Wash., D.C. | | 25a. REC'D BY REGISTRAR DEC 27 1965 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

| <div> <div>1</div> <div> <div>2</div> <div>16878</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>2260</div> </div> | | | | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--|-------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 13 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hyattsville d. STREET ADDRESS 3609 Monroe St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) John D. O'Hearn | | | 4. DATE OF DEATH Dec. 4 1965 | | 5. SEX Male | | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 7 78 | | 9. AGE (In years last birthday) 87 yrs. | | 10. FUND 1 YEAR <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER | | | 11b. KIND OF BUSINESS OR INDUSTRY PRINTER | | | 11. BIRTHPLACE (County & State, or foreign country) LOWELL, MASS. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME JOHN O'HEARN | | | 14. MOTHER'S MAIDEN NAME ELLEN CROWLEY | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO. UNKNOWN | | | 17. INFORMANT JOHN D. O'HEARN | | | Address 5609 MONROE ST. HYATTSVILLE MD. | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, A.S.H.D. DUE TO (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I (this hospital) attended the deceased from Nov. 21 , 19 65 , to Dec. 4 , 19 65 , that I (we) last saw the deceased alive on Dec. 4 , 19 65 , and that death occurred at 5:40 M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Dr. Barry Rosenberg | | | | | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. P.M. STAFF DIRECTOR <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg | | | | | | | | | | 22d. ADDRESS CHEVERLY, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 12-7-1965 | | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | | 23d. LOCATION (city, town or county) (State) SILVER SPRING MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DEC 7 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

MEDICAL CERTIFICATION

44.

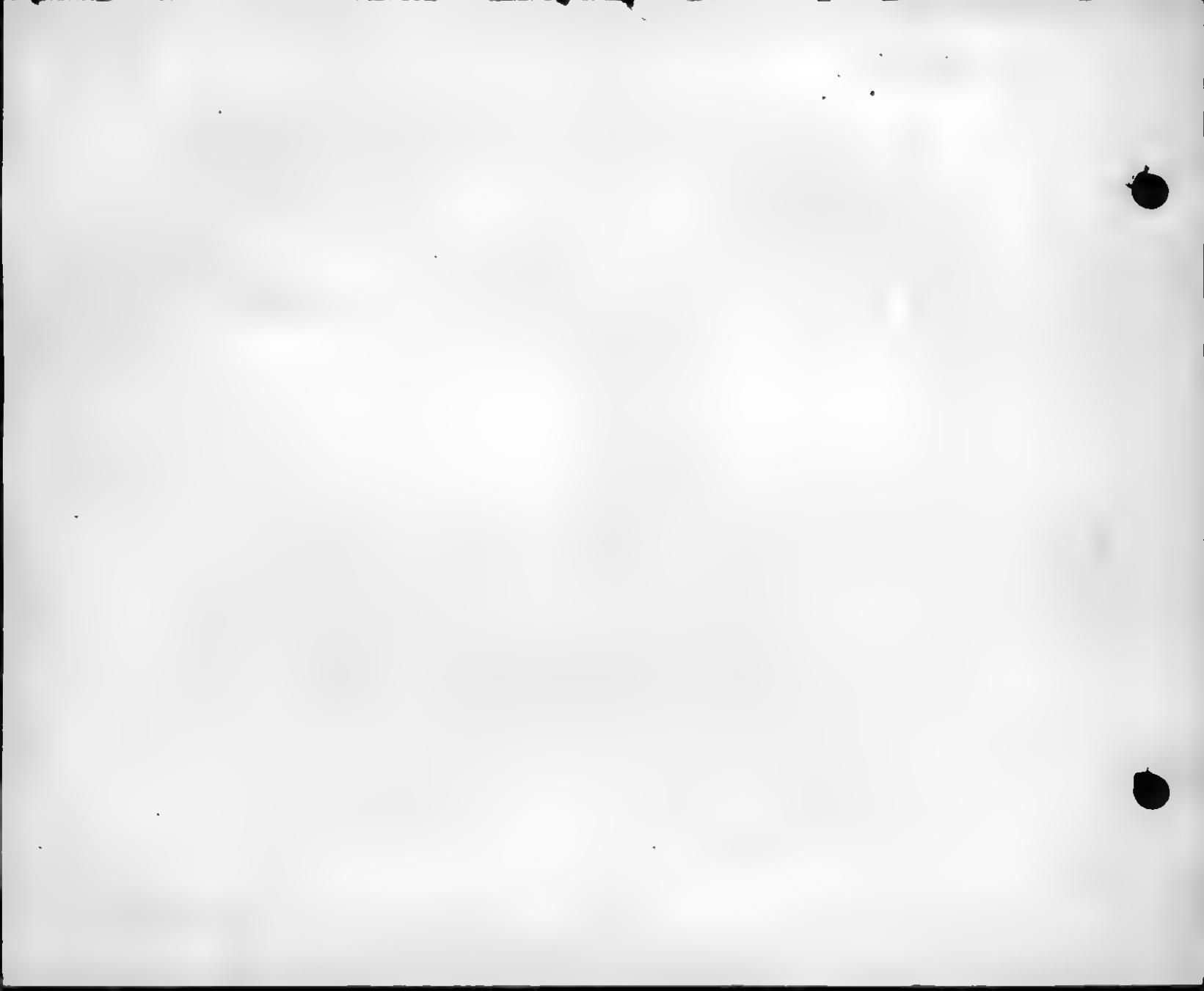
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN ID <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>3520 Duke Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>G</u> Last <u>Payne</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1965</u> | | 5. SEX <u>Female</u> | | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 21, 1898</u> | | 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>D C.</u> | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME <u>Benjamin Goyer</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Lee</u> | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | | | | 16. SOCIAL SECURITY NO. <u>577 26 1039</u> | | | 17. INFORMANT <u>Raymond T. Payne</u> Address <u>3520 Duke st</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure, acute in chronic with uremia</u> (b) <u>6000</u> DUE TO <u>Pyelonephritis, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive cardiovascular disease</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> m. <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>12/10</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>65</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Peter Duus</u> | | | | | | | | 22b. DATE SIGNED <u>Dec. 10, 1965</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Peter Duus, M.D.</u> | | | | | | | | 22d. ADDRESS <u>6124 Central Ave. Capitol Heights, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>12-14-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u> | | | 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> | | | | | | 25a. REC'D BY REGISTRAR <u>DEC 15 1965</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | |

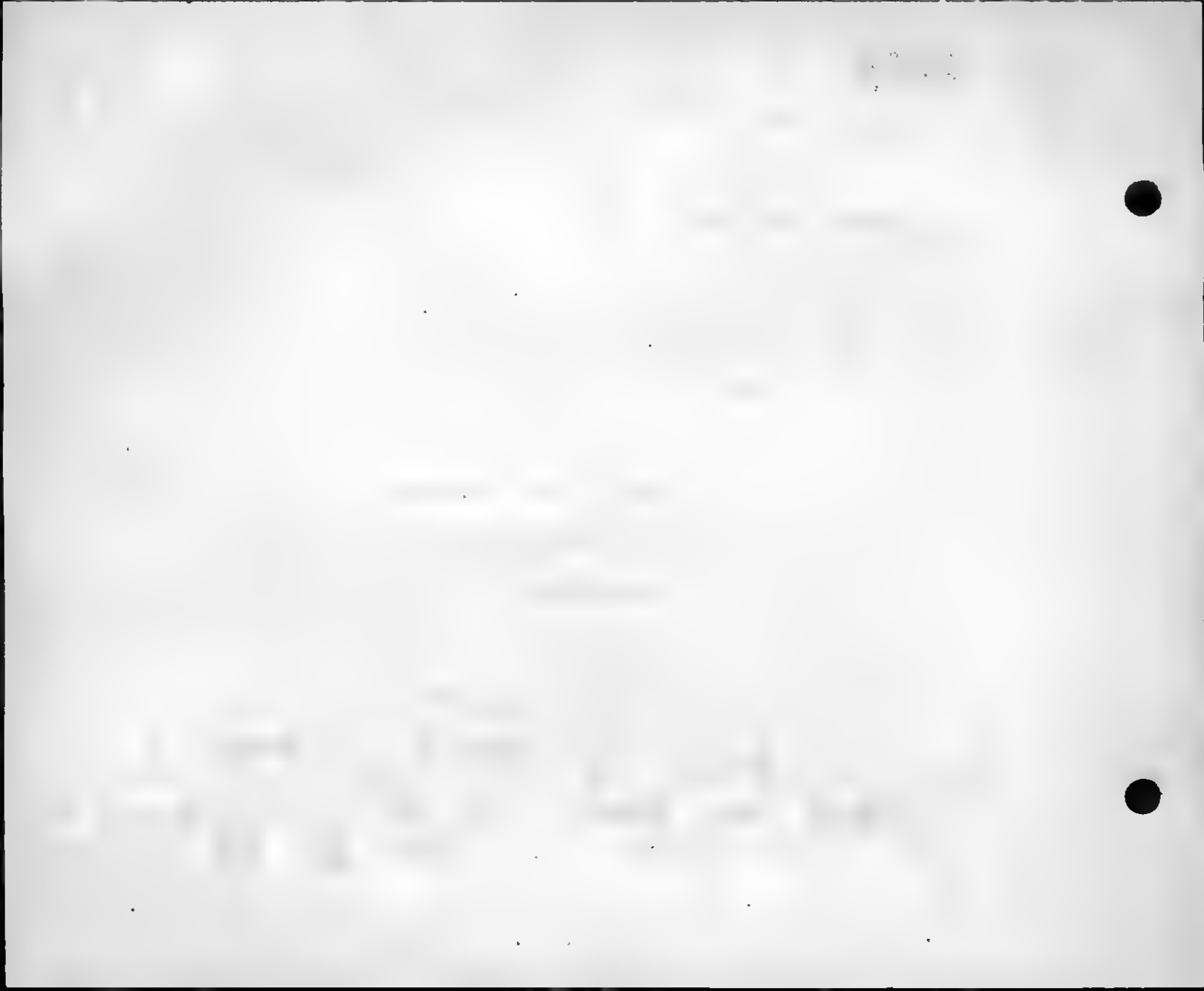


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16880 **CERTIFICATE OF DEATH** 1262

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | |
| c. LENGTH OF STAY IN 1b 13 hr | | d. STREET ADDRESS 6423 Landover Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle H Last Phillips | | 4. DATE OF DEATH Month Dec. Day 12 Year 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2 Feb., 1908 |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY U S Government | |
| 11. BIRTHPLACE (County & State, or foreign country) California | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Horatio Phillips | | 14. MOTHER'S MAIDEN NAME Nellie Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Jennie R Phillips | | Address Cheverly, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Occlusion (anterior descending) DUE TO (c) Coronary Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from December 11, 1965 , to December 12, 1965 , that (I) (we) last saw the deceased alive on December 12, 1965 , and that death occurred at 7:35 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Frederick Henry Wilhelm | | 22b. DATE SIGNED December 13 1965 | |
| 22c. PHYSICIAN'S NAME (Type) Frederick Henry Wilhelm, M.D. | | 22d. ADDRESS 6319 Landover Road, Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 14, 1965 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DEC 16 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

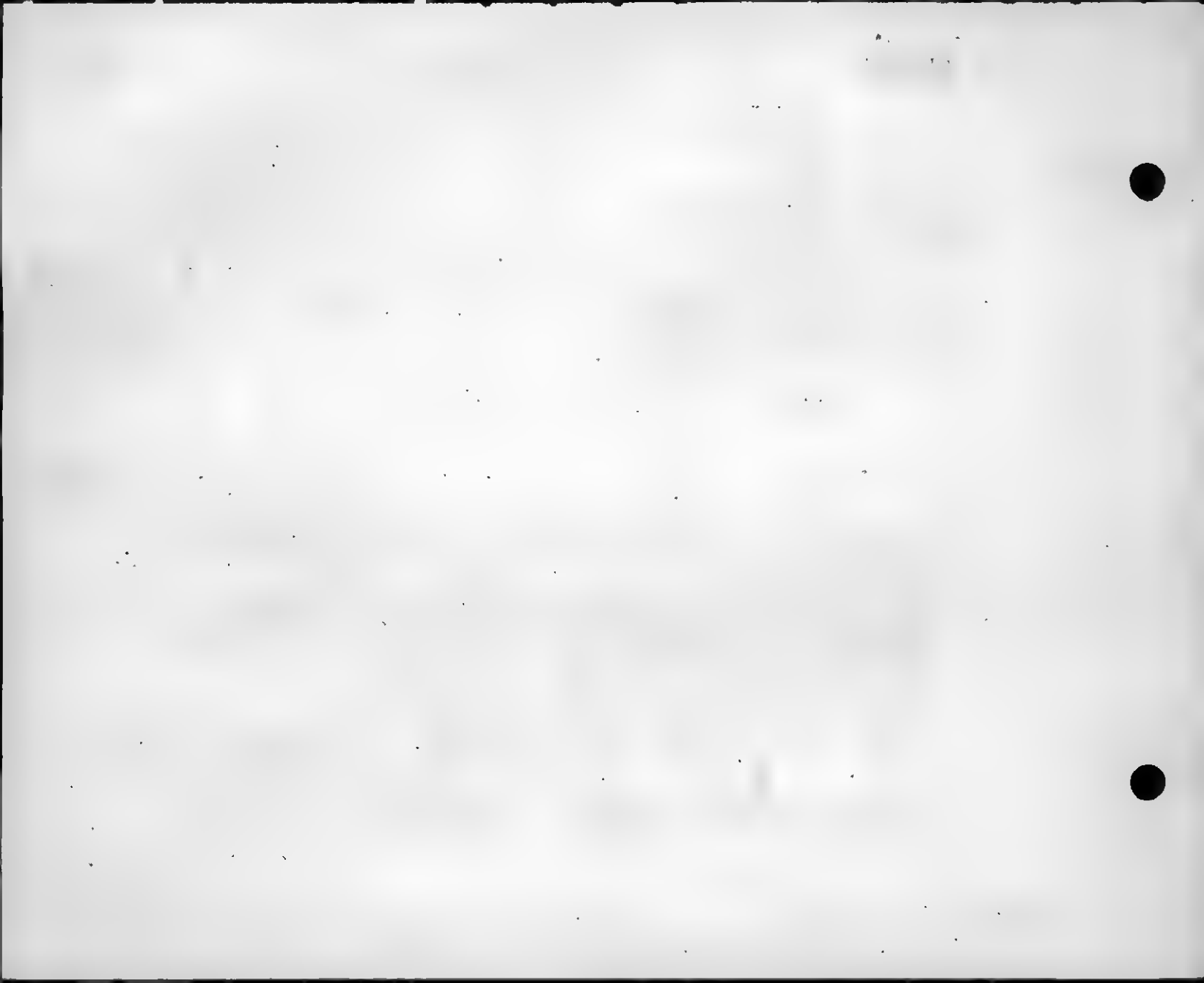


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16281
CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville c. LENGTH OF STAY IN 1b Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forestville Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 3429 80th Ave, North e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Addie Elsie Pickett First Middle Last 4. DATE OF DEATH Dec. 31 19 65 Month Day Year | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 14, 1889 76 yrs. 9. AGE (in years last birthday) Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY US Govt. 11. BIRTHPLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George Marshall 14. MOTHER'S MAIDEN NAME Mary Allen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Frances Pickett Address Same as #2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute Circulatory Failure 4 hrs (b) A.S.H.D. & Coronary Insufficiency (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis & Small Brain Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from July, 1965, to Dec 31, 1965, that (I) (we) last saw the deceased alive on Dec 31, 1965, and that death occurred at 10 PM, from the causes and on the date stated above. | |
| 22a. SIGNATURE Kelvin L. Minchin 22c. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN M.D. 22b. DATE SIGNED 12/31/65 22d. ADDRESS 7200 MAHLBORO PINE SE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/4/66 23c. NAME OF CEMETERY OR CREMATORY Washington Natl. Cem. 23d. LOCATION (City, town or county) Suitland Maryland | |
| 24. FUNERAL DIRECTOR J. Wm. Lees Sons, Washington D. C. 300 4th St., NE 25a. REC'D BY REGISTRAR JAN 5 1966 25b. REGISTRAR'S SIGNATURE | | | |



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FOR STATE
HEALTH DEPT.

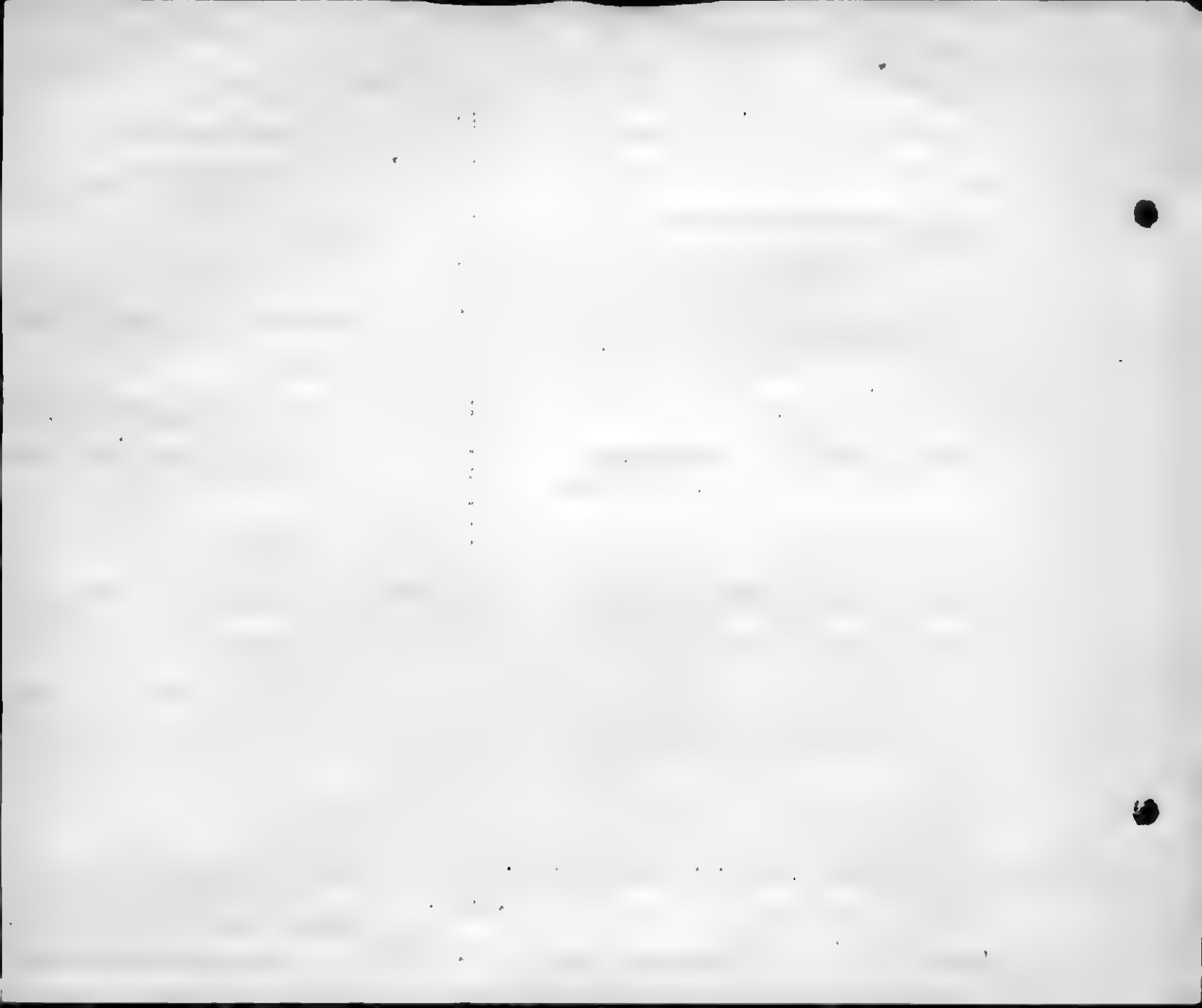
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20264

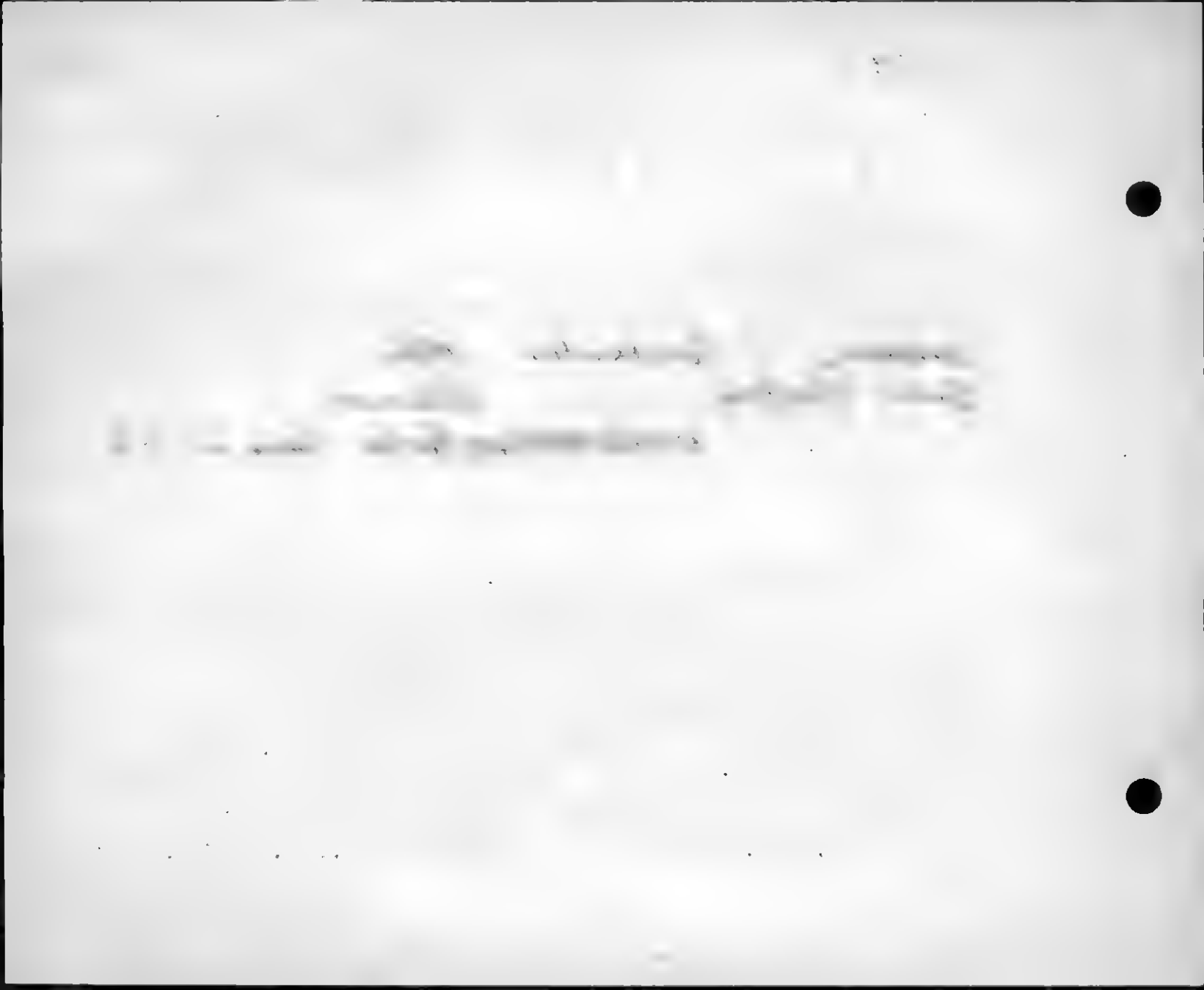
| | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> d. STREET ADDRESS <u>803 Berkshire Drive</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Herbert Edward Pollock</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1965</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4 Aug. 1904</u> | | 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Owner)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Radio & TV Shop</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Logis Pollock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Kellman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Army-WWII</u> | | | | 16. SOCIAL SECURITY NO. <u>Army-WWII</u> | | | | 17. INFORMANT <u>Sarah Pollock 803 Berkshire Rd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>12/24/65</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | | | |
| 23. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u> | | | | ADDRESS <u>3501 14th St., N. W.</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 27 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

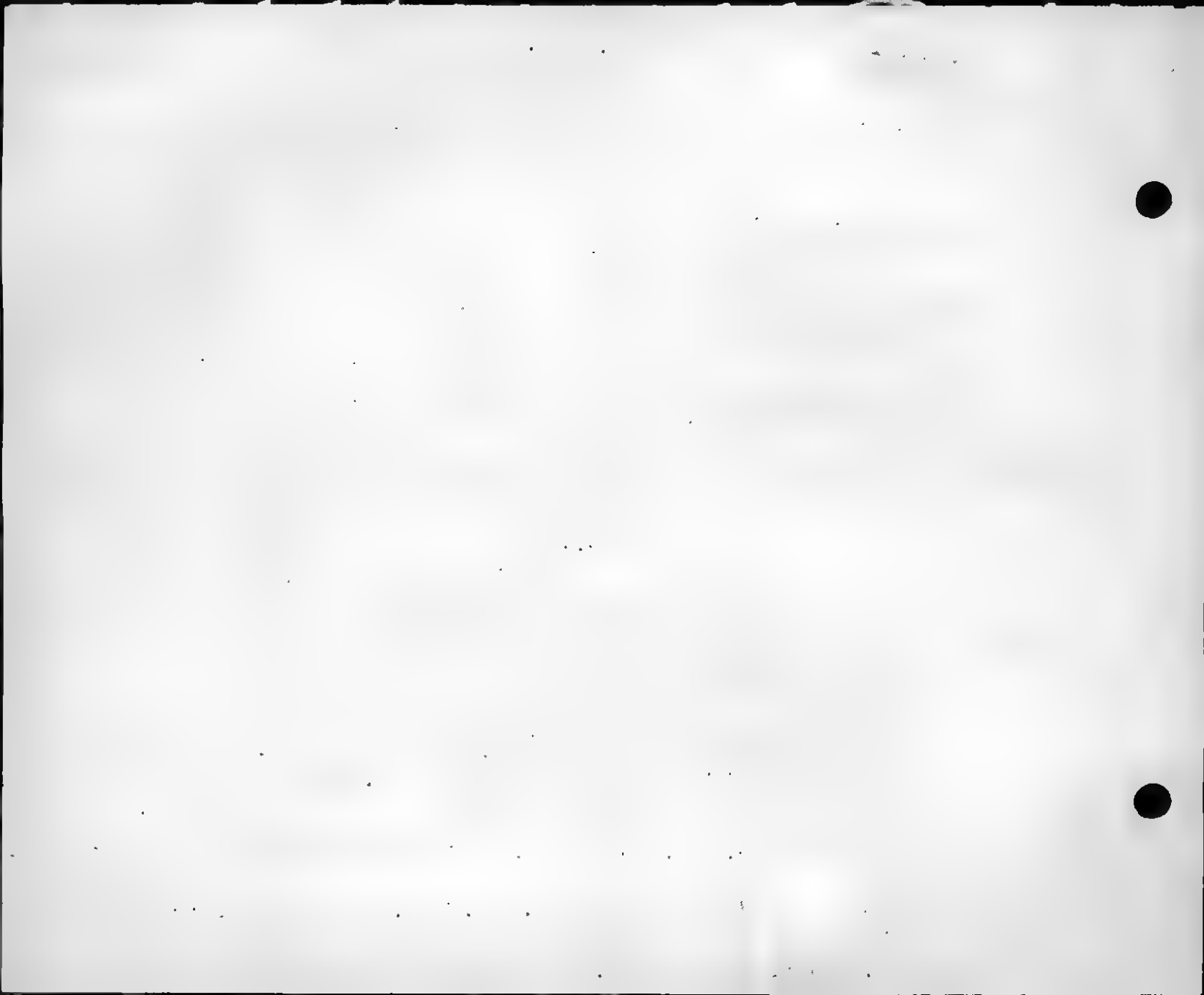
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> 16883 Item #11 Film #311 12/15/65 pc 265 </div> | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 21 days | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cedar Heights | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | | | | | d. STREET ADDRESS 913 62nd Place | | | |
| 3. NAME OF DECEASED (Type or print) Benjamin F Porter | | | | 4. DATE OF DEATH Month December Day 2 Year 1965 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 2, 1900 | | 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | | | 11. BIRTHPLACE (County & State, or foreign country) Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Porter | | | | 14. MOTHER'S M maiden NAME Mary Young | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 579-28-3897 | | 17. INFORMANT Mary Porter | | Address Same as 2D | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Due to (c) male grand arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 11 , 1965, to Dec. 2 , 1965, that (I) (we) last saw the deceased alive on Dec. 2 , 1965, and that death occurred at 9:45 M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Don B. Cameron M.D. | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12-2-65 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Don B. Cameron | | | | | | 22d. ADDRESS 3503 Perry St., Mt. Rainier, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF 12-7-65 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial | | 23d. LOCATION (City, town or county) (State) Highland Park Md | | | |
| 24. FUNERAL DIRECTOR H.S. Washington & Sons | | | | | | ADDRESS 4925 Denno Ave NE. | | 25a. REC'D BY REGISTRAR DEC 7 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |





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MARYLAND STATE DEPARTMENT OF HEALTH

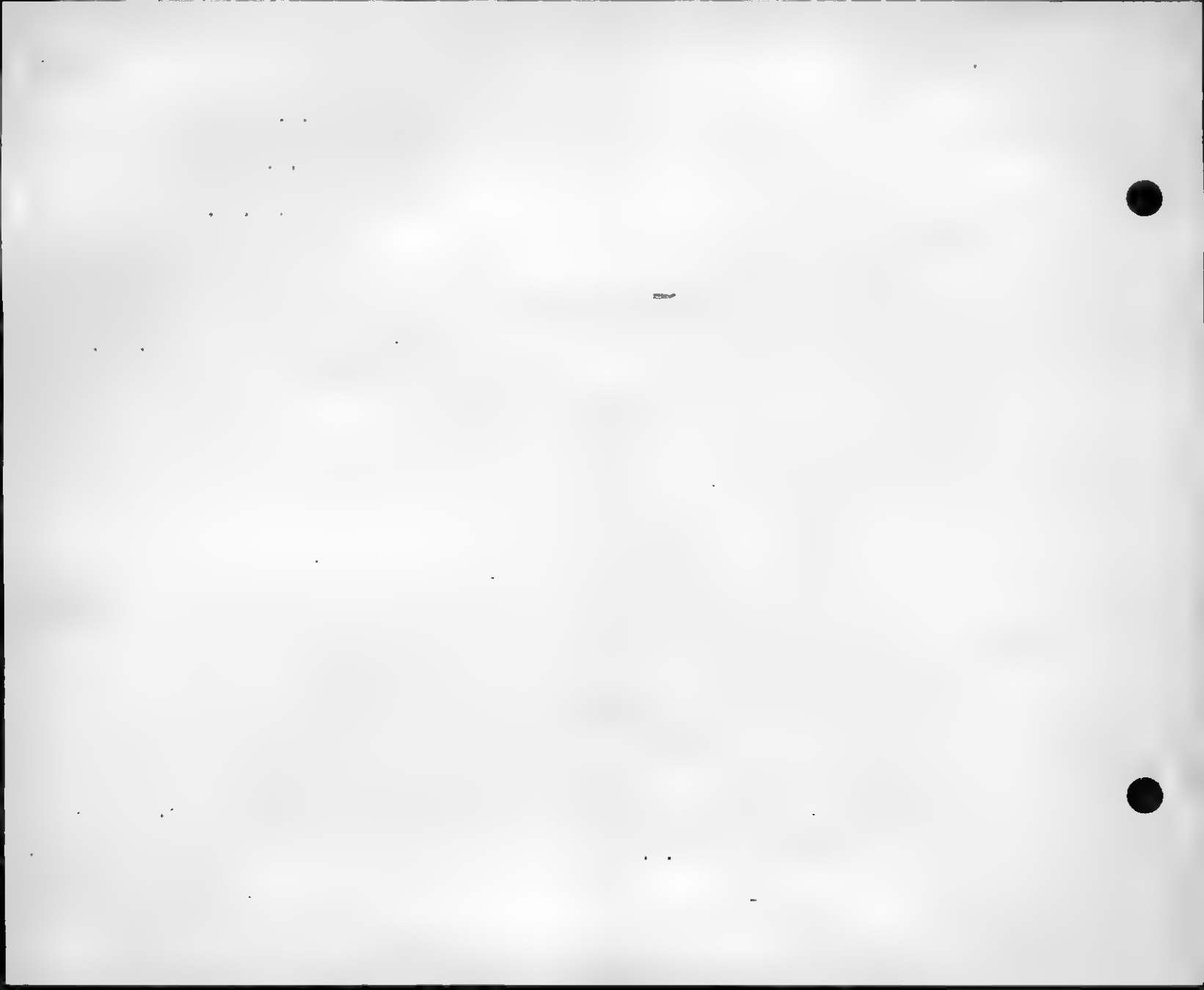
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16885

268

| | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevdrlly c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 522 Decater St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Zdenek | | First Zdenek | | Middle Ptacek | | Last Ptacek | | 4. DATE OF DEATH Month December Day 10 Year 19 65 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 6, 1891 | | 9. AGE (in years last birthday) 74 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Unknown Ptacek | | | | 14. MOTHER'S MAIDEN NAME Mary Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Amelia E. Ptacek | | Address 522 Decatur Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Severe, Bilateral 4201 DUE TO (b) Pulmonary embolism DUE TO (c) Myocardial infraction and fibrosis, massive Arteriosclerotic heart disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/1/65 to 12/10/65 , that (I) (we) last saw the deceased alive on 12/1/65 , and that death occurred at 12/10/65 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Peter Duus | | | | | | 22b. DATE SIGNED Dec. 10, 1965 | | | |
| 22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D. | | | | | | 22d. ADDRESS 6124 Central Ave. Capitol Heights, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-13-65 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Suitland Maryland | | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home | | | | | | ADDRESS 4308 Suitland Rd Suitland Maryland | | 25a. REC'D BY REGISTRAR DEC 15 1965 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

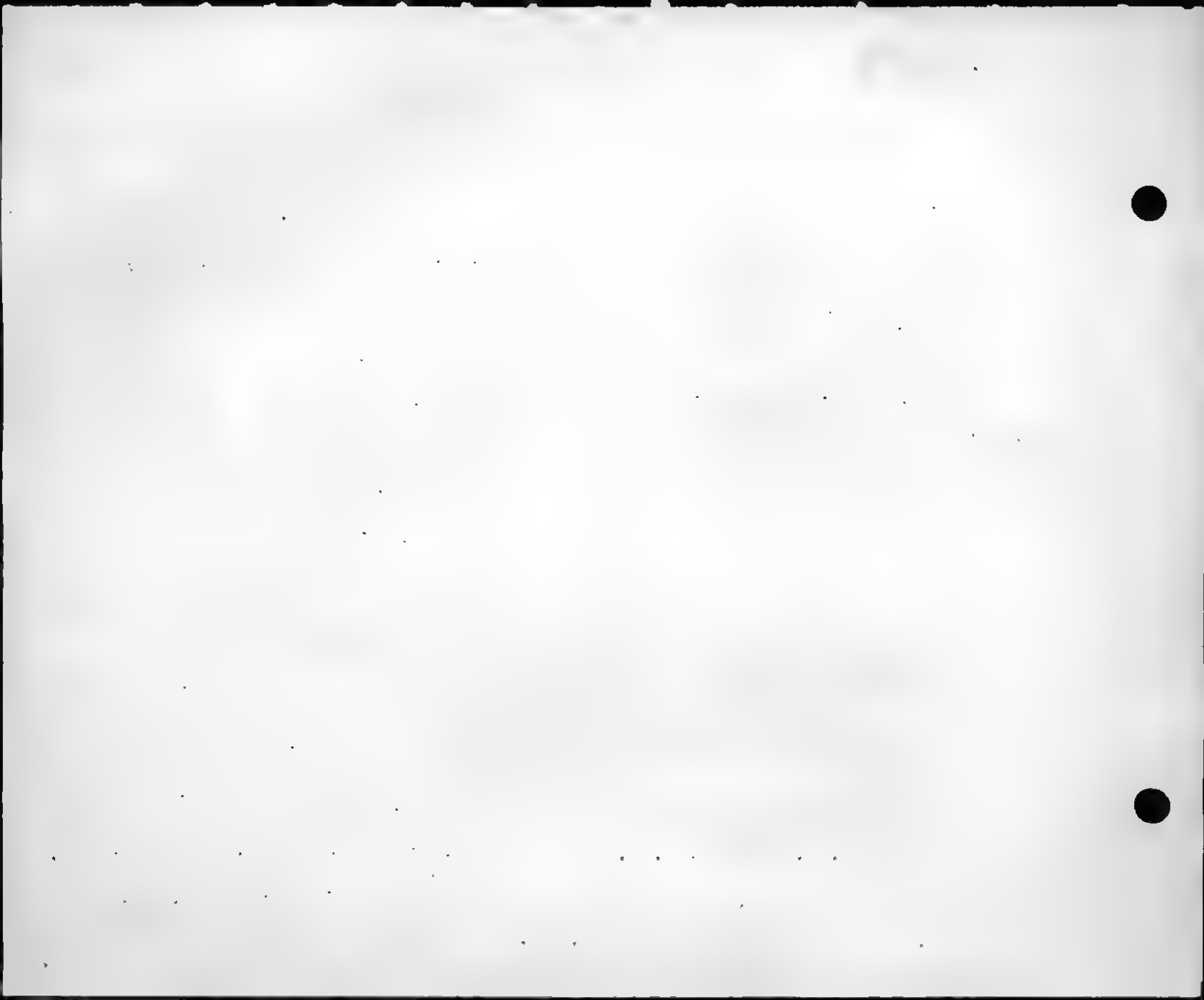


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2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
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| <div style="display: flex; justify-content: space-between;"> 168826 Item #9 Film #3372 1/4/65 267 </div> | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | | | | |
| c. LENGTH OF STAY IN ID MAYLAND | | | | | | d. STREET ADDRESS 4503 Oliver St. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Ethel | | | | | | 4. DATE OF DEATH December 28, 1965 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-10-1878 | | 9. AGE (in years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Scotland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Ballingal Railton | | | | | | 14. MOTHER'S MAIDEN NAME Fleming, Dethia | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Medical Record | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) GEN. ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS UNKNOWN | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 16 DEC. 1965 to 28 DEC. 1965, that (I) (we) last saw the deceased alive on 27 DEC. 1965, and that death occurred at 7:00 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE C. J. Houmann | | | | | | | | | | | |
| 22b. DATE SIGNED 28 DEC. 1965 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D. | | | | | | | | | | | |
| 22d. ADDRESS 4404 Queensbury Road, Riverdale, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | | 23b. DATE THEREOF Dec 28, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory | | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md. | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DEC 30 1965 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | | | |



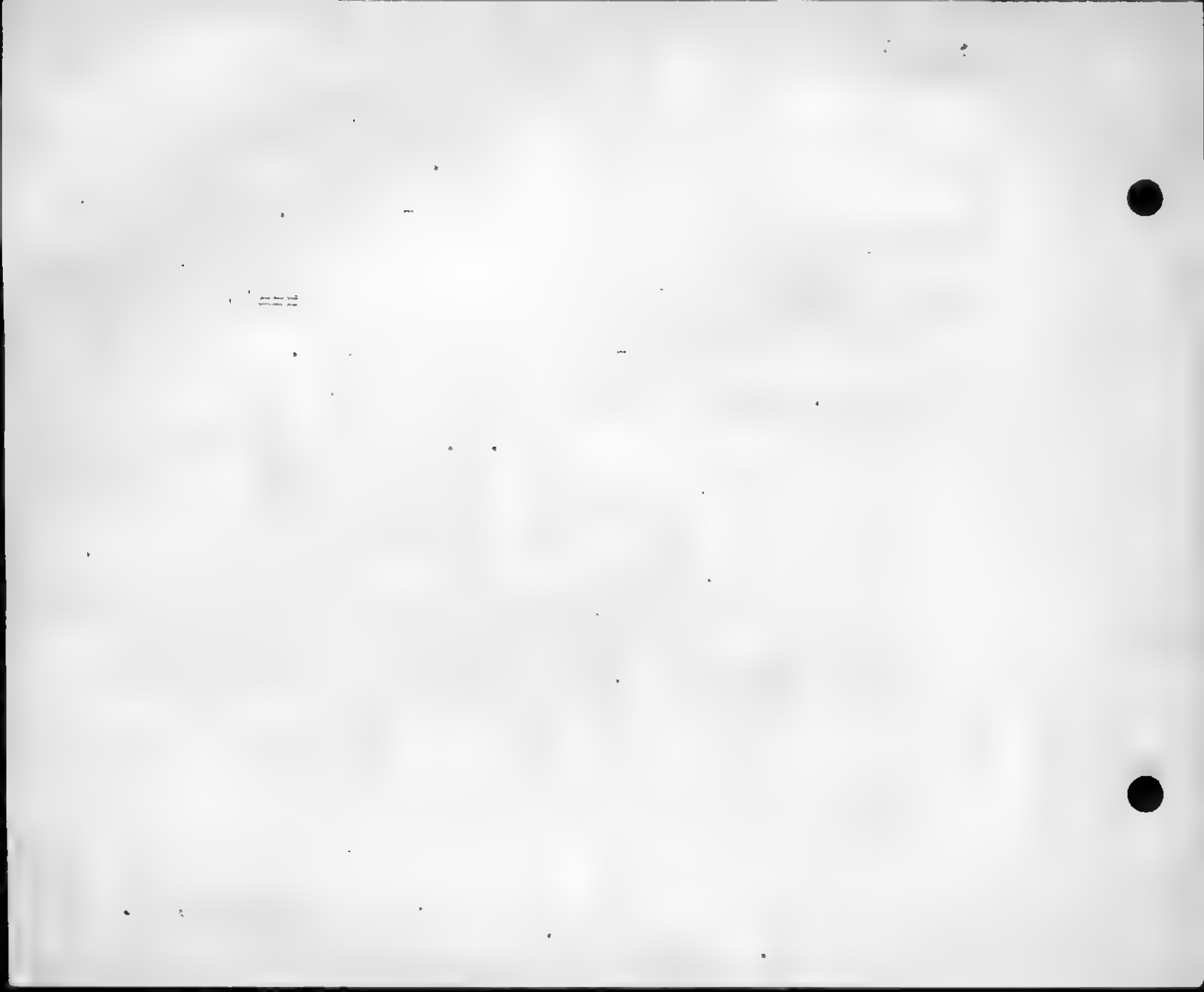
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16887

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphia</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Rainier</u> | |
| c. LENGTH OF STAY IN 1b <u>2 years</u> | | d. STREET ADDRESS <u>4017 - 31st St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Point Branch Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED First <u>MARY</u> Middle <u>Rice</u> Last <u>Rice</u> (Type or print) <u>MADELINE</u> | | 4. DATE OF DEATH <u>12-17-1965</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OF RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-15-1888</u> |
| 9. AGE (In years last birthday) <u>75</u> | | 10. FINDER 1 YEAR <u>75</u> FINDER 24 HRS. <u>75</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Hollywood, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S.</u> | |
| 13. FATHER'S NAME <u>George W. Latham</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Burroughs</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Mr. J. Russell Rice (above address)</u> | | Address <u>(Husband)</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> +221 DUE TO <u>Anteroseptal myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>10 yrs.</u> (c) <u>10 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe cryptogenic asthma.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that <u>(the hospital)</u> attended the deceased from <u>4-8</u> , 19 <u>64</u> , to <u>12-17</u> , 19 <u>65</u> , that <u>(we)</u> last saw the deceased alive on <u>12-15</u> , 19 <u>65</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE <u>R.D. Bauer M.D.</u> | | 22b. DATE SIGNED <u>12-18-65</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u> | | 22d. ADDRESS <u>2513 Buckleup Rd. Adelphi, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/20/65</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Nailey's Funeral Home Inc.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 22 1965</u> | |
| ADDRESS <u>Mt. Rainier Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



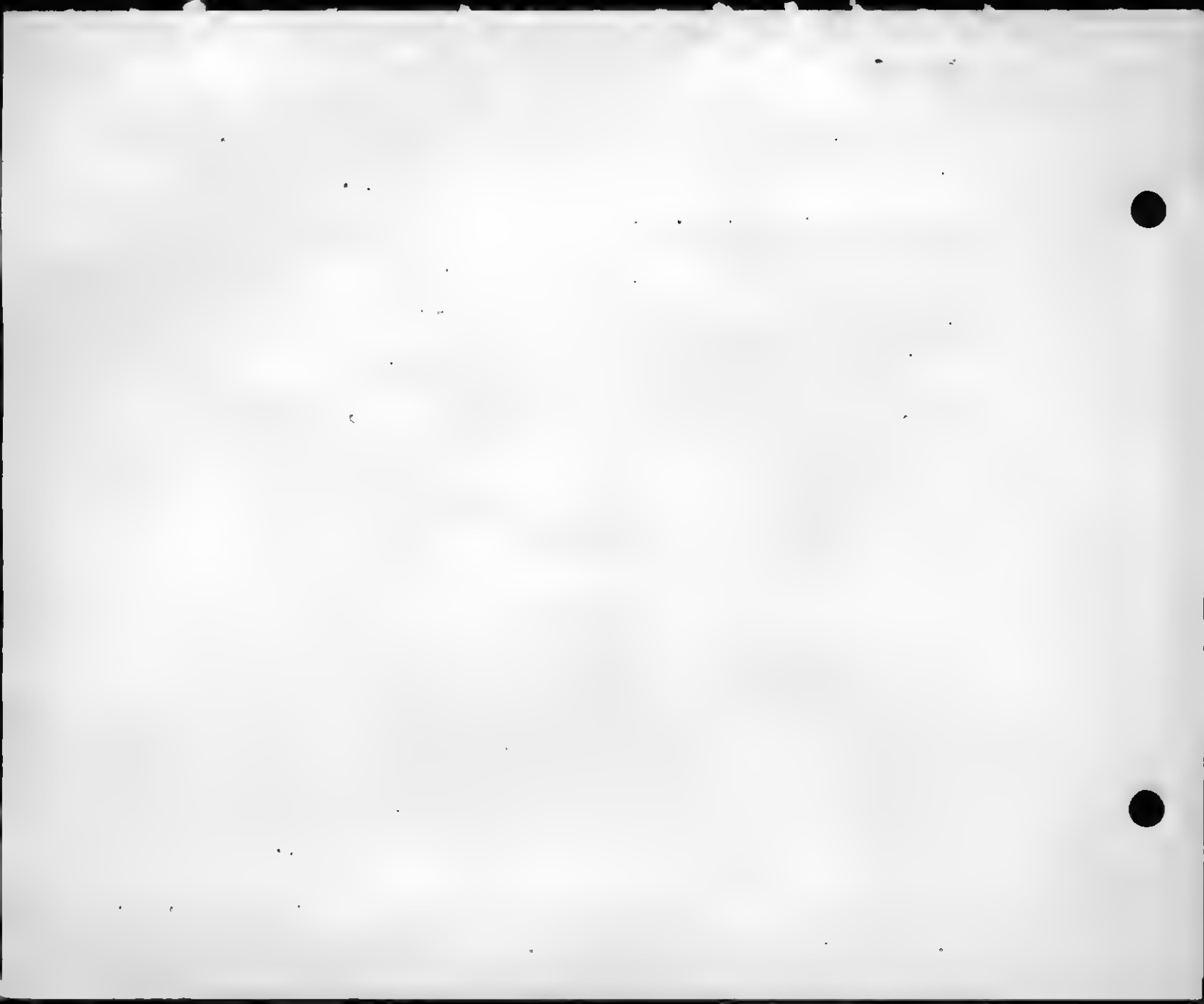
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Pr. Georges | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1d | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville, | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 4217 Jefferson Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ray Plympton Ridley | | 4. DATE OF DEATH Month Day Year 12/ 9 1965 | | 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/3/15 | | 9. AGE (in years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months Days 12/ 9 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Ridley, Vinton | | 14. MOTHER'S MAIDEN NAME Florence | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Medical Records. | | Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 6 MOS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 18 AUG. , 19 65 , to 9 DEC. , 19 65 , that (I) (we) last saw the deceased alive on 9 DEC. 19 65 , and that death occurred at 4:45 PM , from the causes and on the date stated above. | | 22a. SIGNATURE C. J. HOCMANN | | 22b. DATE SIGNED 10 DEC 1965 | | 22c. PHYSICIAN'S NAME (Type) C. J. HOCMANN | |
| 22d. ADDRESS RIVERDALE MD. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 13, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | |
| 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. | | 24. FUNERAL DIRECTOR r. Gasch's Sons | | 25a. REC'D BY REGISTRAR DEC 16 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

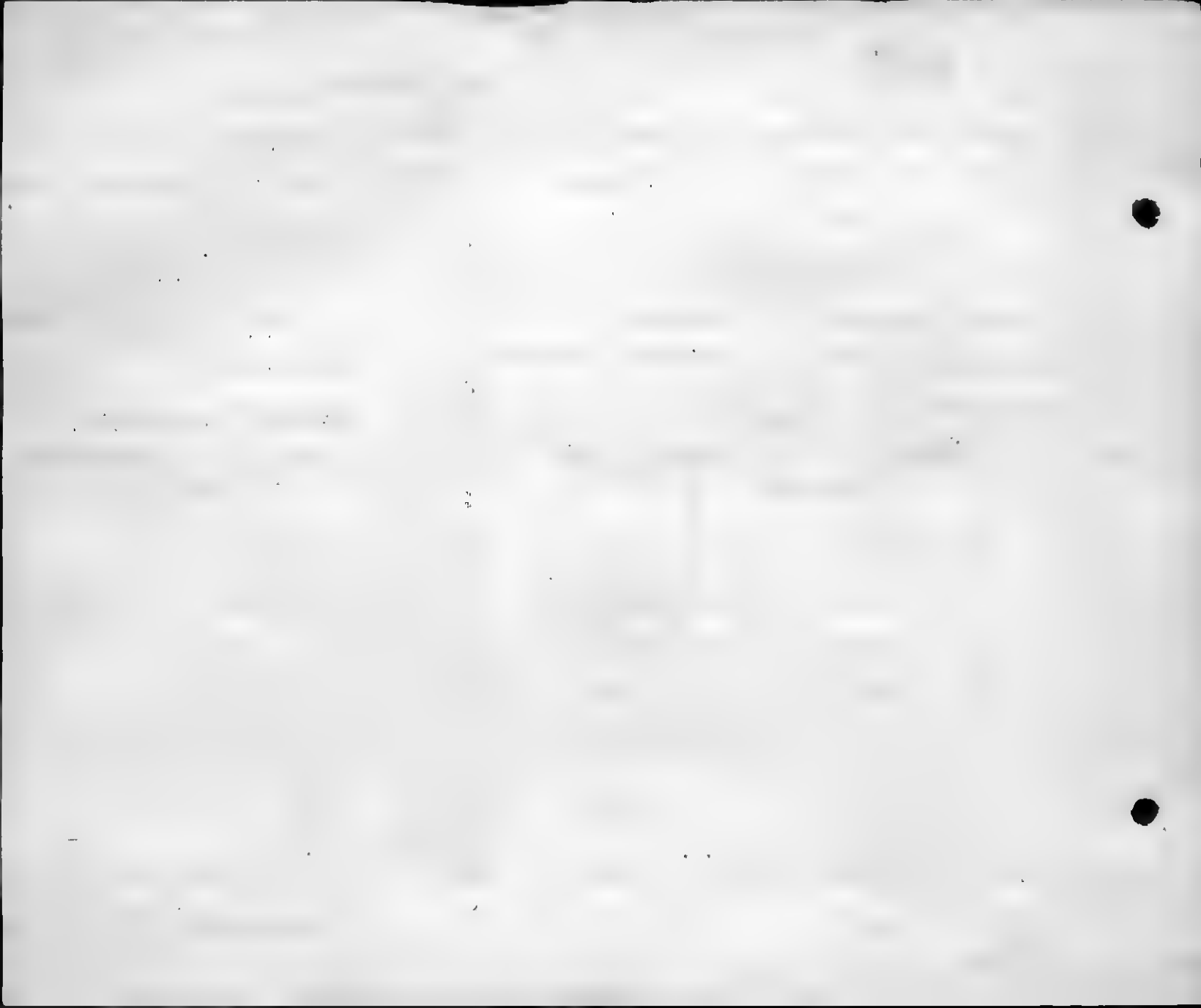
VR A15ME
SM 1/63

16889

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

270

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's same as in 2 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 4704 Woodberry Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles D Riefkin | | 4. DATE OF DEATH Dec. 21 19 65 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 2, 1903 | 9. AGE (In years last birthday) 62 yrs. | 10. IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY MANAGEMENT ENGINEERING | | 11. BIRTHPLACE (State or foreign country) KENTUCKY | |
| 13. FATHER'S NAME ISAAC RIEFKIN | | 14. MOTHER'S MAIDEN NAME ANNA LUKOWSKY | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 400 22 8806 | | 17. INFORMANT DOROTHY B. RIEFKIN Address SAME AS # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary infarct 41 3X DUE TO (b) Pulmonary embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Thrombophlebitis of legs | | | | | INTERVAL BETWEEN ONSET AND DEATH days 3 weeks 4 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12-22-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md. | | | |
| | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | 22b. DATE THEREOF 12-22-1965 | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN | 22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND | | |
| 23. FUNERAL DIRECTOR W.W. Chambers Co- Riverdale, Md. | | 24a. REC'D BY REGISTRAR DEC 28 1965 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |

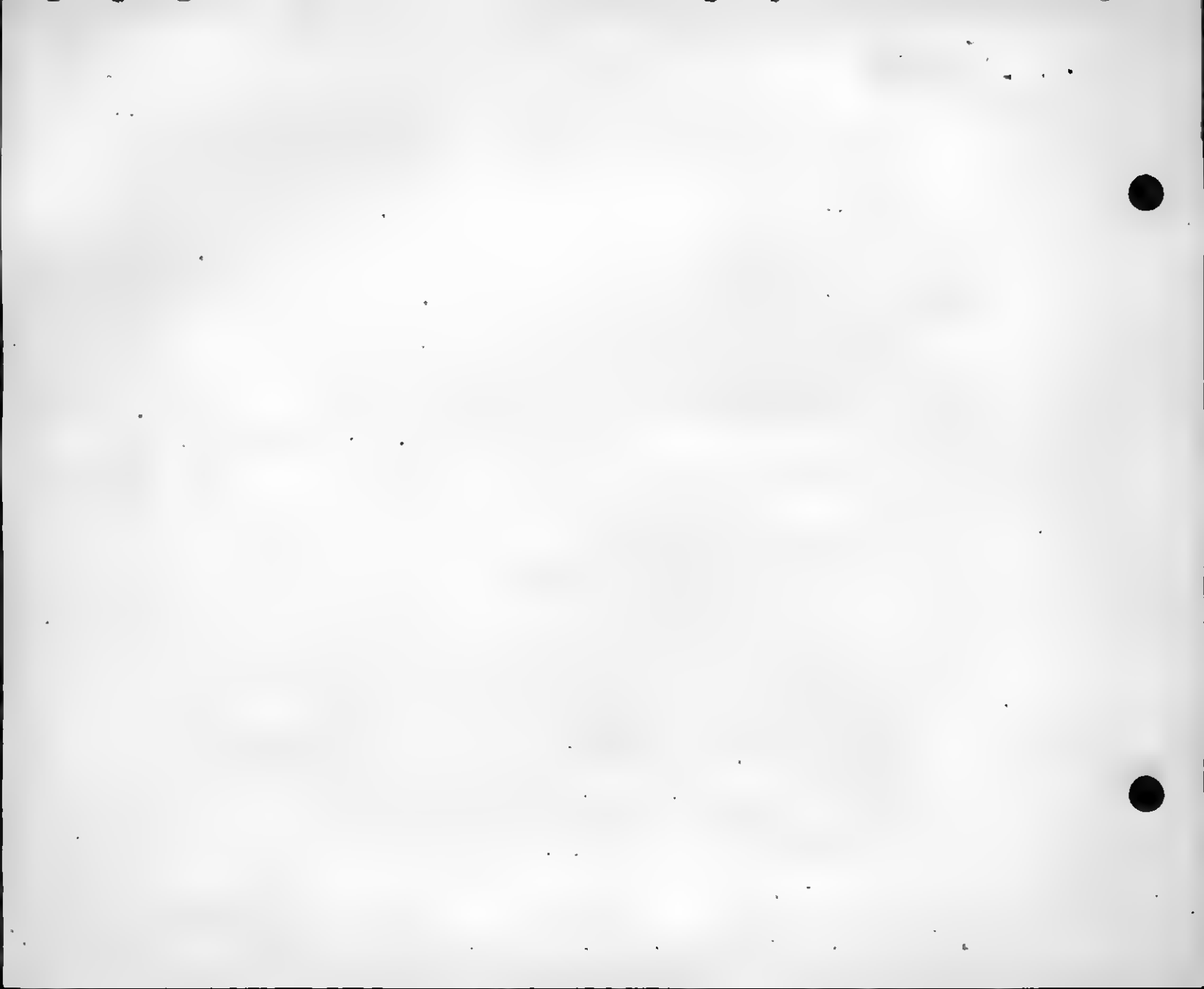


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 16890 CERTIFICATE OF DEATH 271 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND b. COUNTY PRINCE GEORGE'S | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X BRANDYWINE | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 2 Box 277 | | | | | d. STREET ADDRESS ROUTE 2 BOX 277 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) RUTH | | First Middle Last H RIGOR | | 4. DATE OF DEATH Dec. 1st 1965 | | Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4 Sept. 1901 | | 9. AGE (in years last birthday) 64 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Washington, DC | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Marshall Johnson | | | | | 14. MOTHER'S MAIDEN NAME Sara Wykes | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Ruth E Physioc 6603-Stockton Lane | | | Address Hyattsville Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis (b) (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate Days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 21 July, 1965, to 12 Oct, 1965, that (I) (we) last saw the deceased alive on 12 Oct 1965, and that death occurred at M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Stephen Kaufmann | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 2 Dec 65 | | |
| 22c. PHYSICIAN'S NAME (Type) STEPHEN KAUFMANN, M.D. | | | | | 22d. ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AF | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF Dec. 2-1965 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION (City, town or county) (State) Suitland Maryland | | | |
| 24. FUNERAL DIRECTOR Simmons Bros | | | | ADDRESS 1661-Good Hope Rd SE Wash DC | | 25a. REC'D BY REGISTRAR DEC 3 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



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MARYLAND STATE DEPARTMENT OF HEALTH

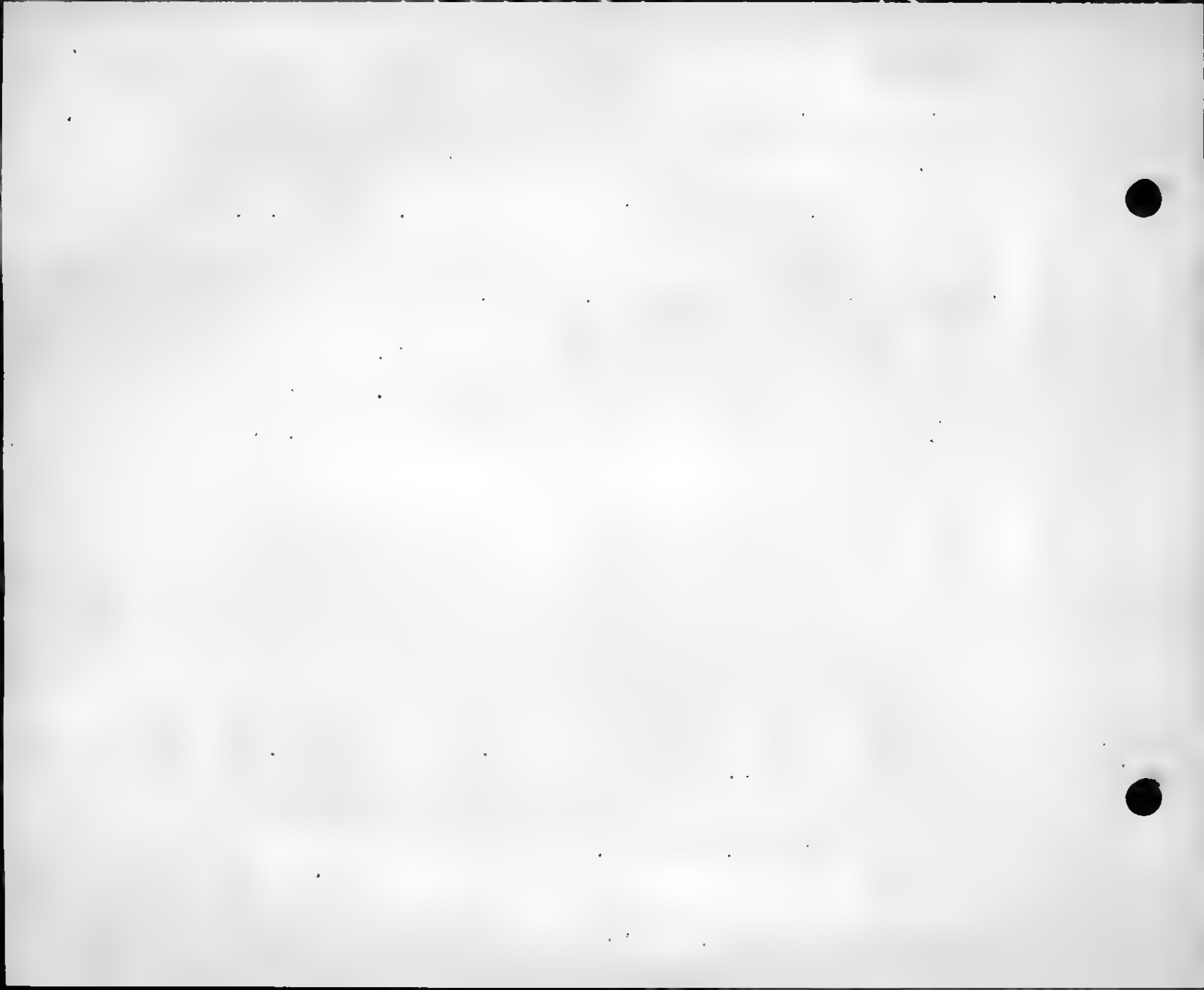
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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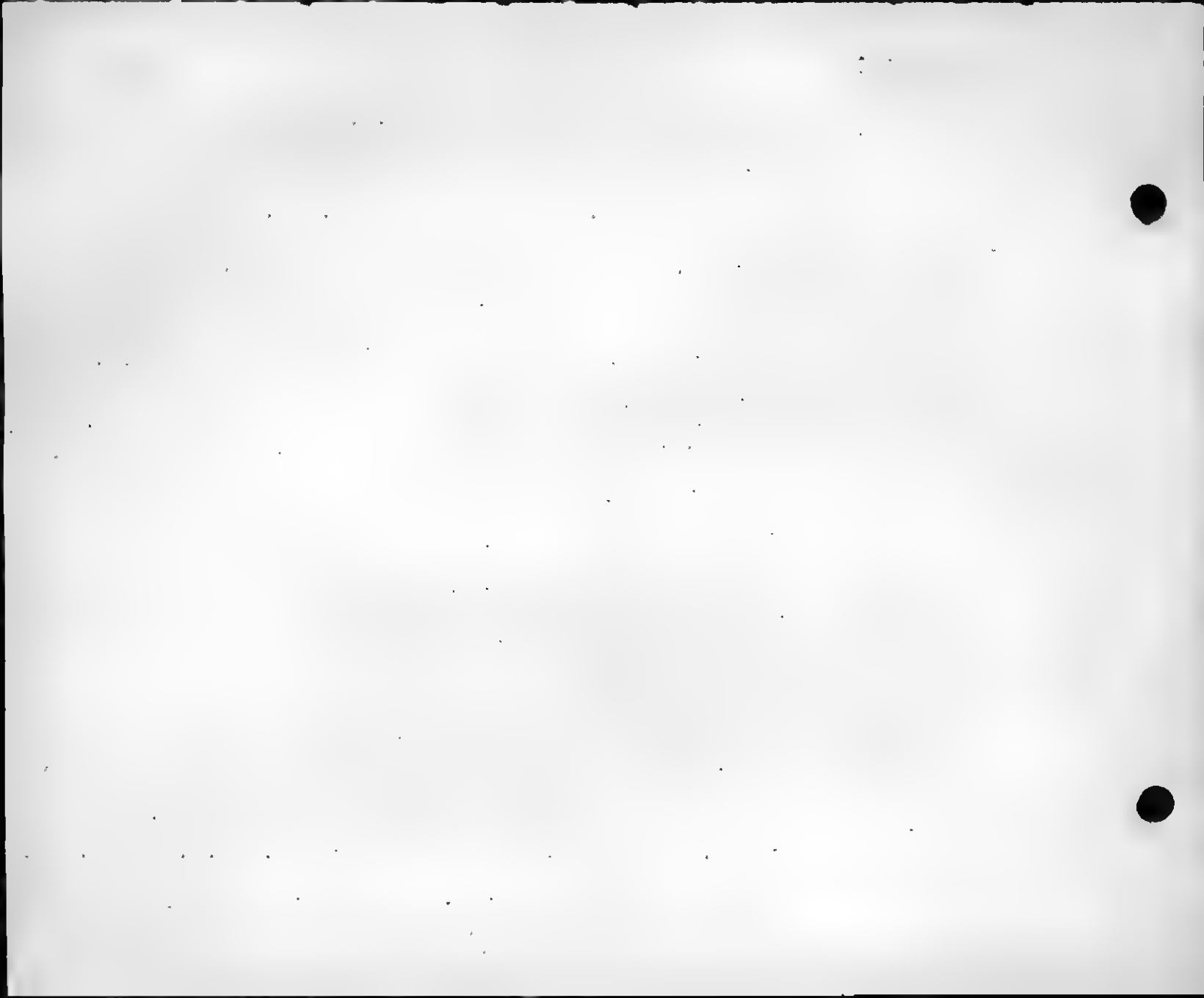
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 8 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Rosa | | Middle Robertson | | Last Robertson | | 4. DATE OF DEATH Month December Day 26 Year 1965 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 28, 1885 | | 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME Mary F. Coleman | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Florence Brown | | Address same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 wk | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 18 , 19 65 , to Dec. 26 , 1965, that (I) (we) last saw the deceased alive on Dec. 26 , 19 65 , and that death occurred at 5:30 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Frank J. Talbot | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/27/65 | | | |
| 22c. PHYSICIAN'S NAME (Type) Frank J. Talbot, M.D. | | | | | | 22d. ADDRESS 4307 Branch Ave Marlow Heights Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12-30-1965 | | 23c. NAME OF CEMETERY OR CREMATORY Wernham Mc Memorial | | | | 23d. LOCATION (City, town or county) (State) 7601 - Sheriff Rd. | | | |
| 24. FUNERAL DIRECTOR HOFFMAN FUNERAL HOME | | | | | | ADDRESS 909-6 st | | 25a. REC'D BY REGISTRAR DEC 30 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Switland</u> c. LENGTH OF STAY IN 1b. <u>20 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Switland Nursing Home, Inc.</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1307 "V" St., S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Forrest A. Rodenbaugh</u> | | | First Middle Last | | 4. DATE OF DEATH <u>Dec. 20,</u> 19 <u>65</u> Month Day Year | | 5. SEX <u>W</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/30/1883</u> 9. AGE (in years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Rodenbaugh</u> 14. MOTHER'S MAIDEN NAME _____ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>234-16-0421</u> 17. INFORMANT <u>Richard Rodenbaugh Memphis, Tenn.</u> <u>416 Woodland Circle</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO (b) <u>C.V.R. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Gen. Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____ | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) (County) (State) _____ | | | |
| 21. I certify that (1) this hospital attended the deceased from <u>1964</u> , 19 _____, to <u>12-29, 1965</u> that (1) (we) last saw the deceased alive on <u>12/28/65</u> , and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Bernard J. Katzen, M.D.</u> 22b. DATE SIGNED <u>12/29/65</u> 22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Katzen, M.D.</u> 22d. ADDRESS <u>2645 Naylor Rd., S.E., Wash., D.C.</u> | | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/31/65</u> 23b. DATE THEREOF <u>Cedar Hill Cemetery</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Switland, Md.</u> 23d. LOCATION (City, town or county) (State) _____ | | | | |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> 25a. REC'D BY REGISTRAR <u>James Judge</u> 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> <u>4308 Switland Rd.</u> 25c. ADDRESS <u>Switland, Md.</u> 25d. DATE <u>JAN 6 1966</u> | | | | | | | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

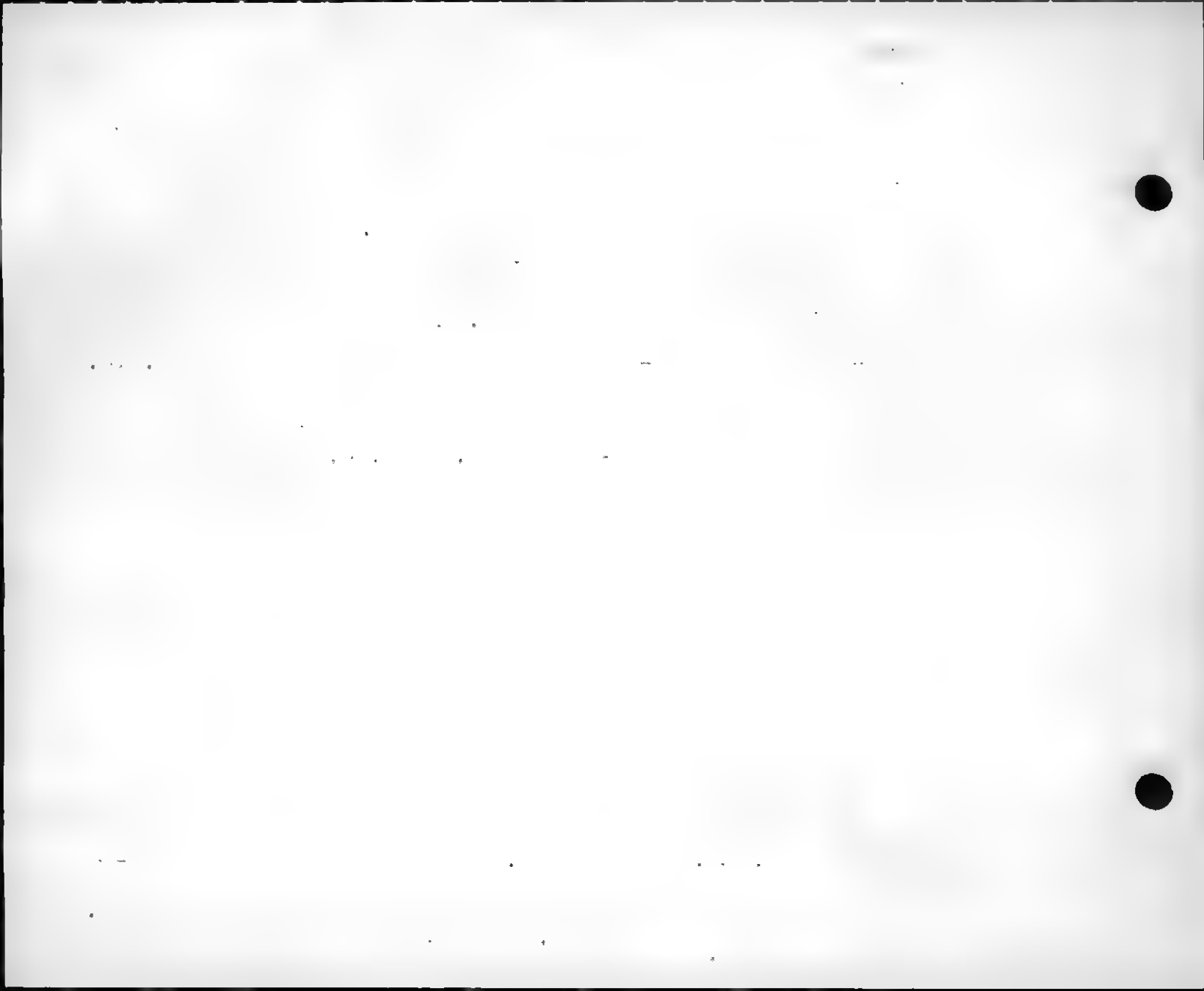
FOR STATE
HEALTH DEPT.

16893

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY N 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. STREET ADDRESS 3820 37th. Place | |
| 3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Rothery | | 4. DATE OF DEATH Month 12 Day 31 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 3, 1900 |
| 9. AGE (In years last birthday) 65 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman- Retired | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Rothery | | 14. MOTHER'S MAIDEN NAME Catherine O'Connor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 134-03-5932 | |
| 17. INFORMANT Mrs. Eliz. M. Meek (above address) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS 340 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 20 yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 1-2-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE THEREOF 1/4/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or town) (County) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | ADDRESS Mt. Rainier, Maryland | |
| 25a. REC'D BY REGISTRAR JAN 6 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



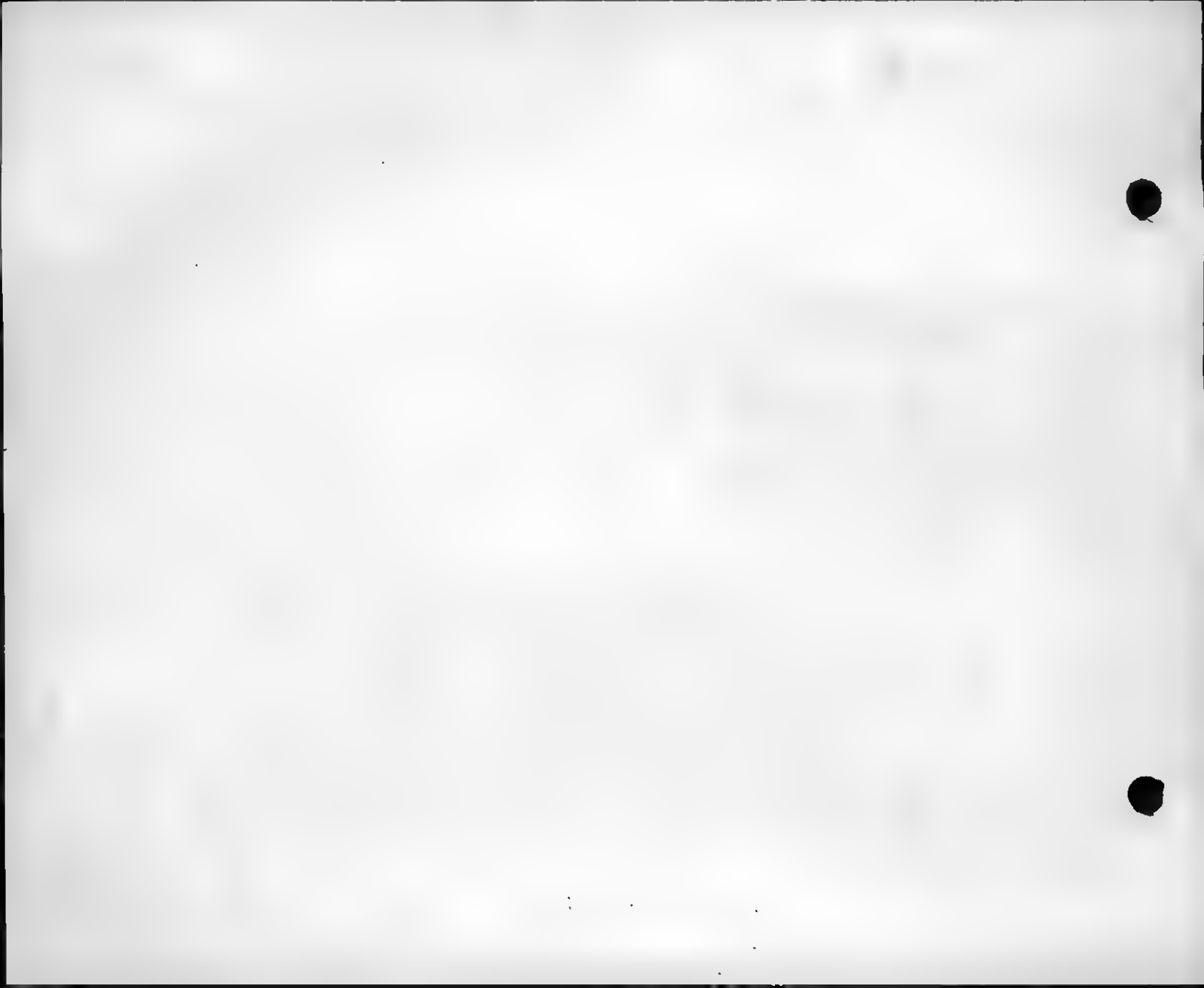
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 16894 Item #11 Film #5372 12/24/65 pg 1275 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 14 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chapel Oaks | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | | d. STREET ADDRESS 5313 Addison St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jesse Ezra Ruffin | | | 4. DATE OF DEATH Month Day Year Dec., 12 19 65 | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 18 Sept. 1888 | | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Millen, Georgia | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Jerry Ruffin | | | | | 14. MOTHER'S MAIDEN NAME Untersaun | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/27 1965 to 12/12 1965, that (I) (we) last saw the deceased alive on 12/11 1965, and that death occurred at 6:45 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Louis Mendel | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/13/65 | | |
| 22c. PHYSICIAN'S NAME (Type) C. LOUIS MENDEL | | | | | 22d. ADDRESS 1410-74th AVE HYATT. Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12-16-65 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park | | 23d. LOCATION (City, town or county) (State) Ind | | | |
| 24. FUNERAL DIRECTOR Morris A. Carter & Co. 305-H ST. N.W. | | | | | 25a. REC'D BY REGISTRAR DEC 21 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16895

2276

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE (RURAL) - HYATTSVILLE</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES COUNTY HOSP</u> | | | | d. STREET ADDRESS <u>11808 LINCOLN AVE.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>A.</u> Last <u>Russell</u> | | 4. DATE OF DEATH Month <u>12</u> - Day <u>18</u> Year <u>1965</u> | | 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-1-1887</u> | | 9. AGE (in years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER (RET.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles H. Russell</u> | | | | 14. MOTHER'S MAIDEN NAME <u>GERTRUDE Schater</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-01-1764B</u> | | 17. INFORMANT <u>MRS. LOUISE M. RUSSELL-1301 OAKVIEW DR. S.W. SPRING MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>Pneumonia</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs - 2 days - 10 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>1962, 19</u> to <u>12-18, 1965</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>12-18, 1965</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>R.D. Bauer</u> | | | | 22b. DATE SIGNED <u>12-18-65</u> | | 22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, M.D.</u> | |
| 22d. ADDRESS <u>2573 Buckle Ridge Rd. Beltsville Md.</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | |
| 23b. DATE THEREOF <u>12/22/65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>WAUGH CEMETERY</u> | | 23d. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR <u>LEONARD J. RUCK INC. 5305 HARFORD RD.</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 20 1965</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



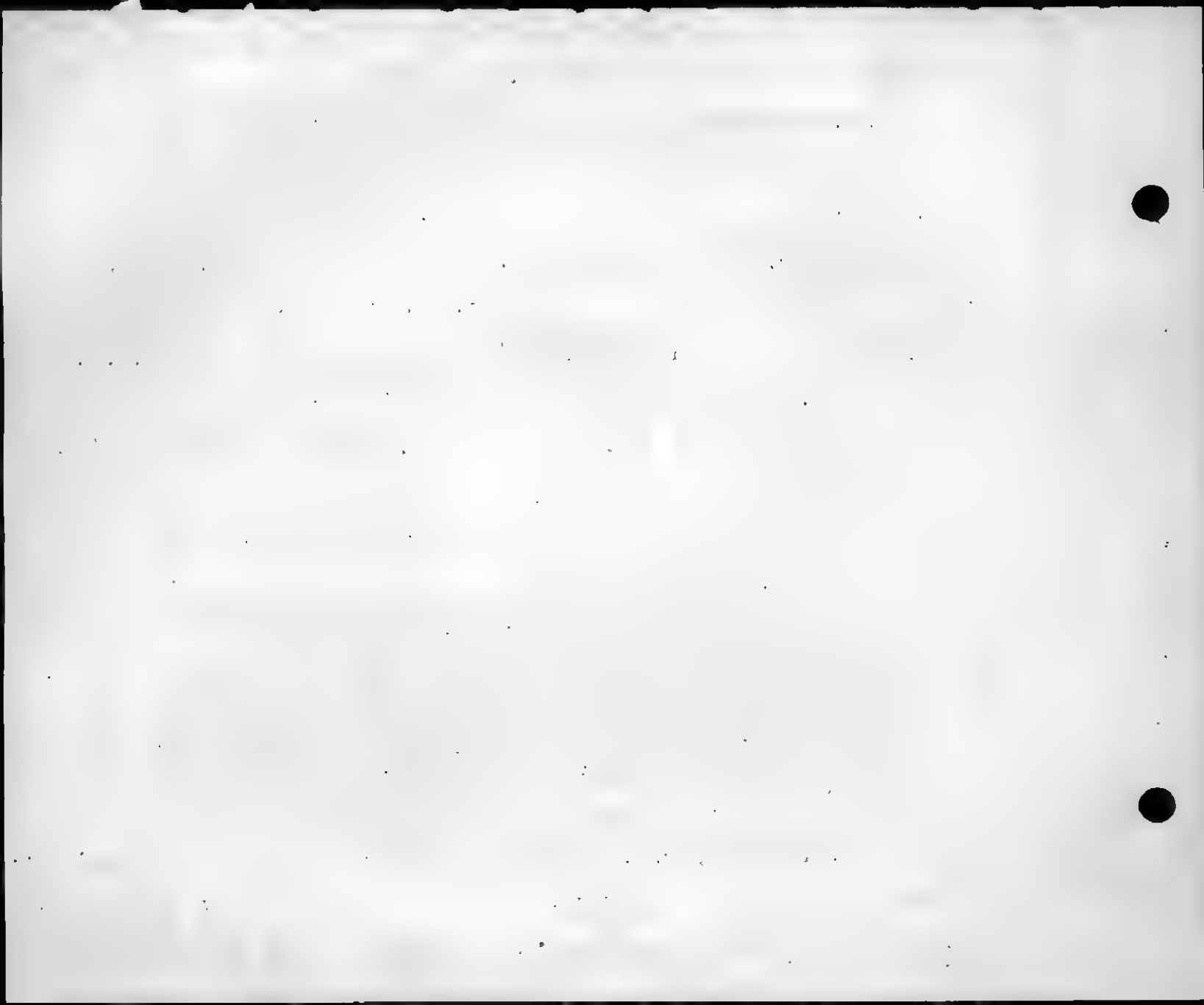
Dr. John Kehoe, Notified and approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 16896 CERTIFICATE OF DEATH 1277 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENBELT | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENBELT | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 F. WESTWAY | | | | | d. STREET ADDRESS 2 F. WESTWAY | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) RALPH JOHNSON RUSSELL | | | First Middle Last | | 4. DATE OF DEATH Dec. 6, 19 65 | | Month Day Year | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 10, 1896 | | 9. AGE (In years last birthday) 69 yrs. | |
| | | | | | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (County & State, or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME WILLIAM RUSSELL | | | | | 14. MOTHER'S MAIDEN NAME MARTHA JOHNSON | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16. SOCIAL SECURITY NO. WW 1 177 07 2879 | | 17. INFORMANT MABEL B. RUSSELL Same as #2 (wife) | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4 1 DUE TO (b) Coronary sclerosis (previous thrombosis 9-18-65) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca. of prostate (Radical prostatectomy on 2-16-61) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19 64 to Dec. 6 19 65 , that (I) (we) last saw the deceased alive on 10-27-1965 , and that death occurred at 4:35 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Hans Wodak | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-6-1965 | | |
| 22c. PHYSICIAN'S NAME (Type) Hans Wodak, M. D. | | | | | 22d. ADDRESS Professional Building, Greenbelt, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/9/65 | | 23c. NAME OF CEMETERY OR PREPARATION Restlawn | | 23d. LOCATION (City, town or county) (State) Cash Valley Md. | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DEC 8 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

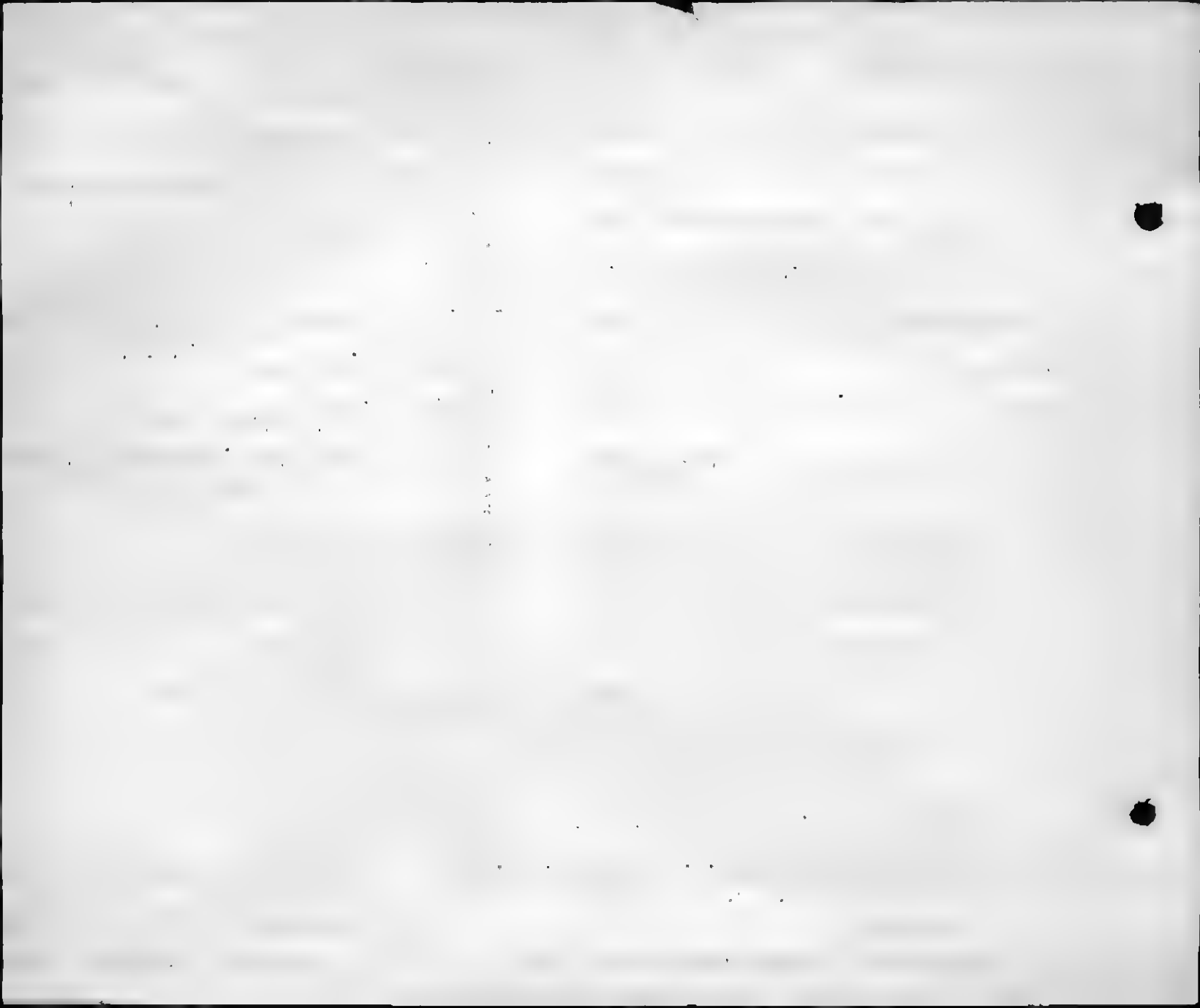


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film G375 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS Stone Foot Road | |
| 3. NAME OF DECEASED (Type or print) Lillian Irene Sager | | 4. DATE OF DEATH 12 28 19 65 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-28-1916 |
| 9. AGE (In years last birthday) 47 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender | | 10b. KIND OF BUSINESS OR INDUSTRY Tavern | |
| 11. BIRTHPLACE (State or foreign country) Harking Co. Ohio | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Emanuel A. Ogg | | 14. MOTHER'S MAIDEN NAME Mary Wilson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Howard Ogg Accokeek, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443x Acute pulmonary edema DUE TO (b) Myocardial fibrosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Hypertensive arteriosclerotic heart disease. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | DATE SIGNED 12-29-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF Dec. 29, 1965 | 22c. NAME OF CEMETERY OR CREMATORY Haldeman Funeral Home | 22d. LOCATION (City, town, or county) (State) Lancaster, Ohio |
| 23. FUNERAL DIRECTOR F. Gasch's Sons, 16 Yorkville, Md. | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JAN 3 1966 J. Charles Judge | |



1
FOR STATE
HEALTH DEPT.

TO DIRECT MEDICAL EXAMINER: This certificate should be examined with 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

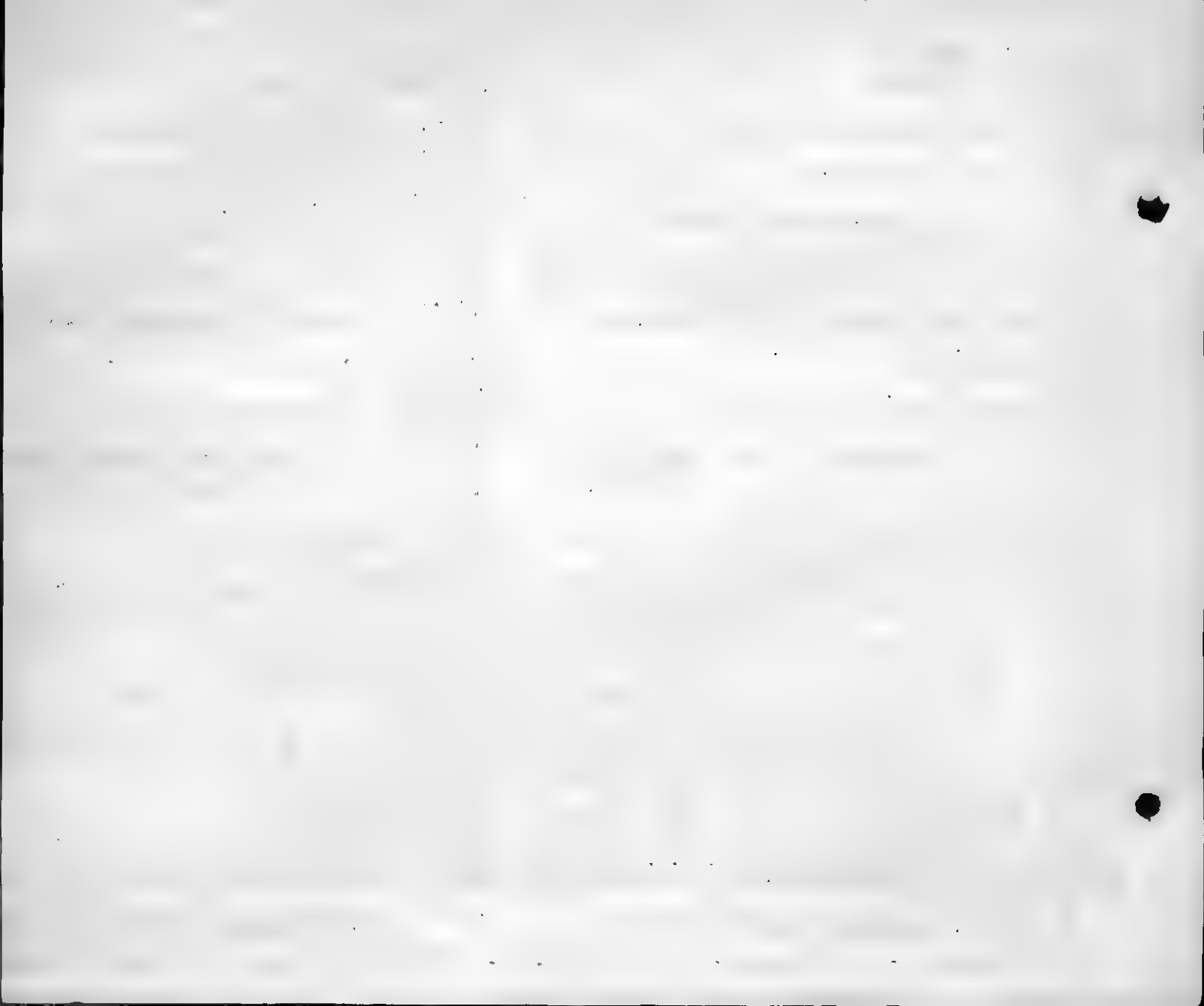
VR AISM
5M 1/63

16898

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0279

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital | | | | d. STREET ADDRESS 622 Silver Spring Ave. | | | |
| 3. NAME OF DECEASED (Type or print) Charles Thomas Schrider | | | | 4. DATE OF DEATH 12 23 19 65 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 31 Jan., 1905 | | 9. AGE (In years last birthday) 60 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Plumbing | | 11. BIRTHPLACE (State or foreign country) Silver Spring, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Thomas Schrider | | | | 14. MOTHER'S MAIDEN NAME Clara Jane Hutchinson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 715-26-0711 | | 17. INFORMANT From Schrider 622 Silver Spring Ave. Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4-201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion of coronary artery (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| 21a. SIGNATURE John Kehoe, M.D. | | | | 21b. DATE SIGNED 12-25-65 | | | |
| 21c. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale | | | | 21d. ADDRESS (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 12-27-65 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR Thomas J. Dunbar, Inc. Silver Spring, Md. | | | | 24a. REC'D BY REGISTRAR 12-28-1965 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |

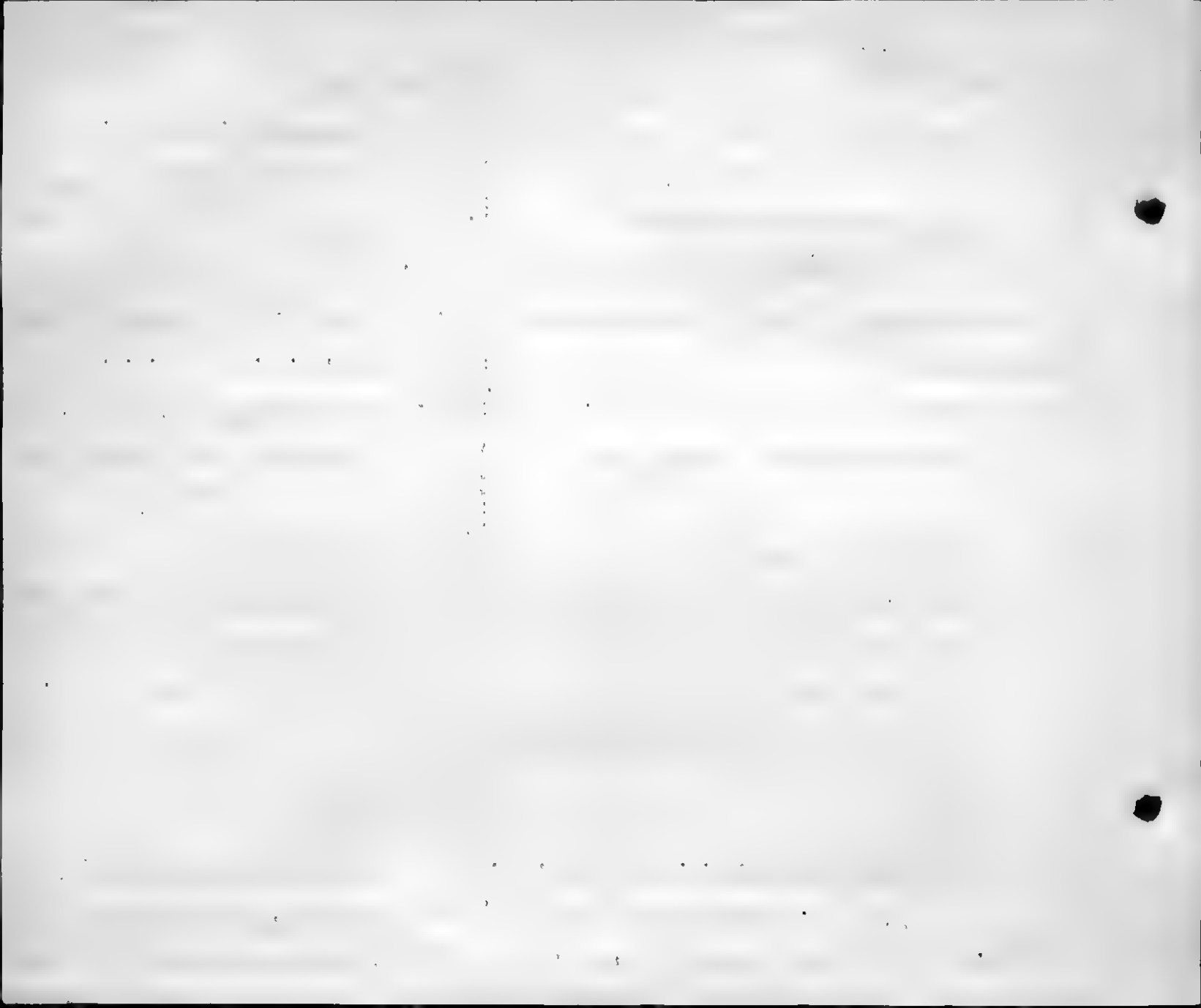


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1980

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY St. Marys Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS Rt. 2, Box 273 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | 4. DATE OF DEATH Month 12 Day 27 Year 19 65 | |
| 3. NAME OF DECEASED (Type or print) First Philip Middle Barton Last Shafer Jr. | | 9. AGE (In years last birthday) 11 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 Aug. 1954 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C. | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PHILIP BARTON SHAFER SR. | | 14. MOTHER'S MAIDEN NAME LOUISE TROSSBACH | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MOTHER SAME AS # 2 ABOVE | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 9110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in back yard of home by accidental discharge of shotgun. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:50amp.m. 12-27-1965 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back yard of home | 20f. (City or town) Same as #2 (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | DATE SIGNED 12-28-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF DEC. 29, 1965 | 22c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDENS | 22d. LOCATION (City, town, or county) WALDORF, MARYLAND |
| 23. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | 24a. REC'D BY REGISTRAR DEC 30 1965 | |
| | | 24b. REGISTRAR'S SIGNATURE J. Charles Judge | |

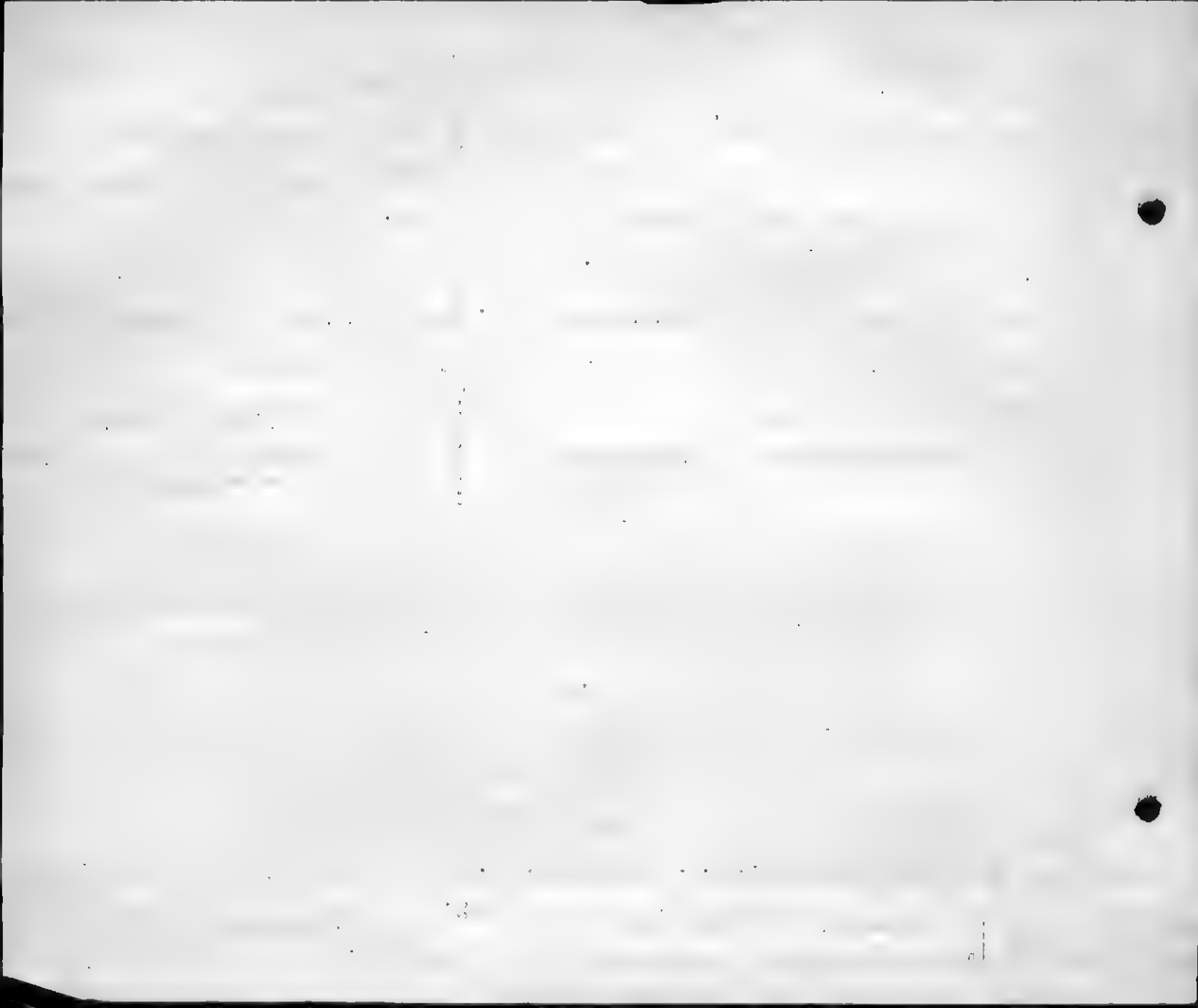


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------|--|------------------|--|--------|------|-------|------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 16 <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> d. STREET ADDRESS <u>834 52nd. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>F.</u> Last <u>Shaw</u> | | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>19 65</u> | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 1885</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <table border="1"> <tr> <td>(If yes give year or dates of service)</td> </tr> </table> | | | | (If yes give year or dates of service) | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | | |
| (If yes give year or dates of service) | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> 4. i. DUE TO <u>rupture of myocardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>From myocardial infarction</u> DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left humerus and left radius - one week</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home.</u> | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>noon</u> p.m. <u>12-7-</u> 19 <u>65</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Same as #2</u> | | (County) | | (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>12-16-65</u> | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>12-18-65</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Scitland, Maryland</u> | | (State) | | | | | | | |
| 23. FUNERAL DIRECTOR <u>W. W. Chambers & Son, 517-11th St. S.E.</u> | | | | | | 24a. REC'D BY REGISTRAR <u>DEC 27 1965</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16901

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 12 days | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville | | d. STREET ADDRESS Queen Ann Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Marshall | | First | | Middle | | Last | | 4. DATE OF DEATH December | | Month | | Day | | Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH 8/13/1903 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months | | Days | | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME William Francis Smith | | 14. MOTHER'S MAIDEN NAME Laura Perrie | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Agnes Louella Smith- | | Address Same as Item #2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pulmonary edema</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <i>arteriosclerotic heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hepatic Coma, embolism of liver</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (i) (this hospital) attended the deceased from Dec. 17, 1965, to Dec. 29, 1965, that (ii) (we) last saw the deceased alive on Dec. 29, 1965, and that death occurred at 12:20M, from the causes and on the date stated above. | | 22a. SIGNATURE <i>Don B. Cameron</i> M.D. | | 22b. DATE SIGNED Dec. 29, 1965 | | 22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1/1/66 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath Com. | | 23d. LOCATION (City, town or county) Annapolis, Md. | | 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. | | 25a. REC'D BY REGISTRAR JAN 10 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | 25c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath Com. | |

Sd [XXXXXXXXXX]

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*mild osteoarthritis

VR A15 (4)
20M 1/65

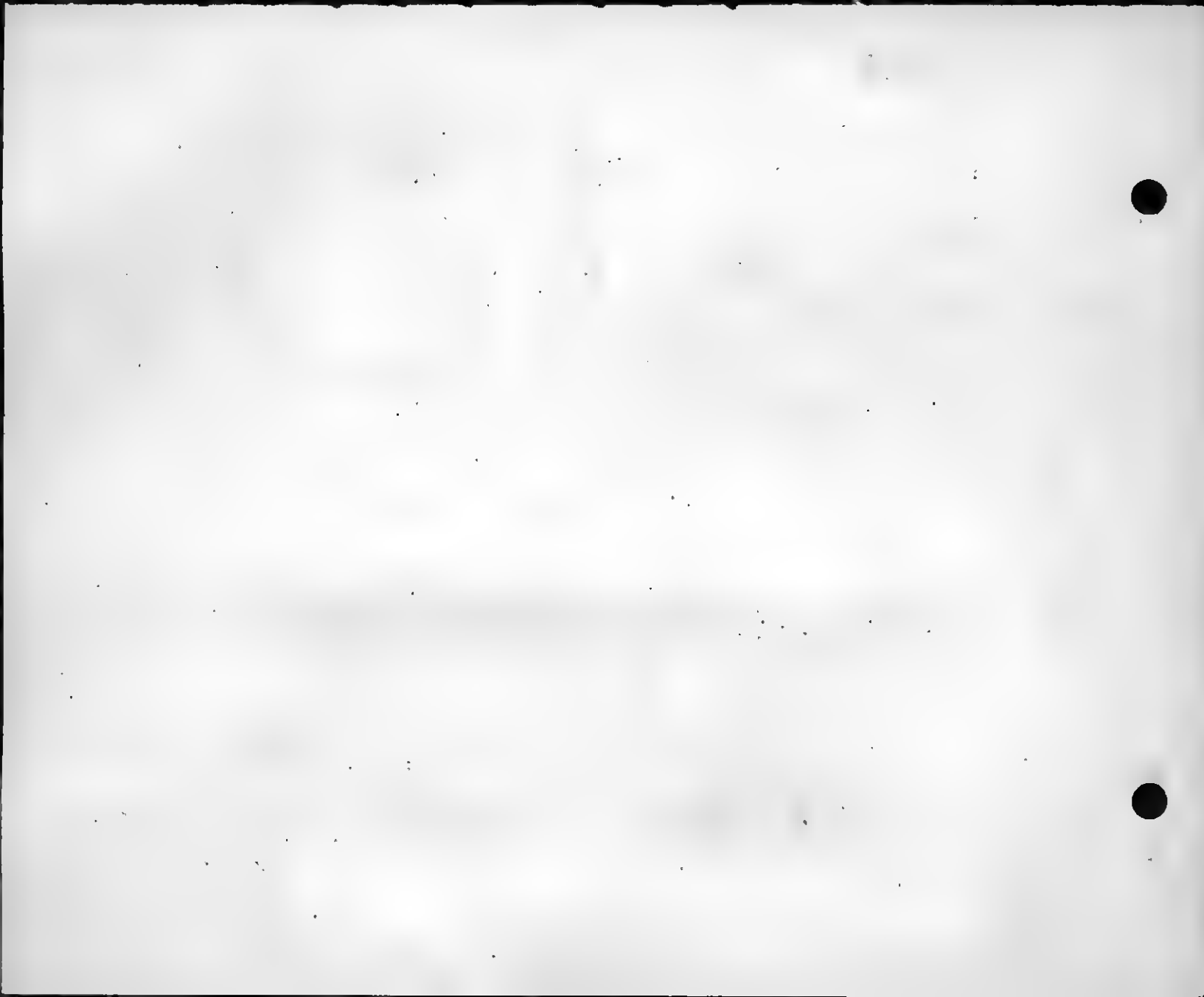
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16902

288

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | | c. LENGTH OF STAY IN 1b 9 mos., 16 dys | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | | | e. STREET ADDRESS 236 11th St. N. E. | | | |
| 3. NAME OF DECEASED (Type or print) Annie T. Stancill | | | | 4. DATE OF DEATH Month Dec. Day 13 Year 1965 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/15/1881 | |
| 9. AGE (in years last birthday) 84 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (County & State, or foreign country) Concord, North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Frank Stancill | | | |
| 14. MOTHER'S MAIDEN NAME Erma Cox | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Decedent | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO (b) 400 DUE TO (c) generalized arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertensive cardiovascular disease; cerebrovascular accident with left hemiparesis; remote; chronic pyelonephritis; diabetes mellitus, * | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/27/61 to 12/13 , 19 65 , that (I) (we) last saw the deceased alive on 12/13 , 19 65 , and that death occurred at 1:30 A. M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | | | 22b. DATE SIGNED 12/13/65 | | | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12-21-65 | | 23c. NAME OF CEMETERY OR CREMATORY Hammonym. Cem | | 23d. LOCATION (City, town or county) (State) MARYLAND | |
| 24. FUNERAL DIRECTOR <i>Joseph H. Street</i> | | | | 25a. REC'D BY REGISTRAR 816 H. ST. N. E. 202 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

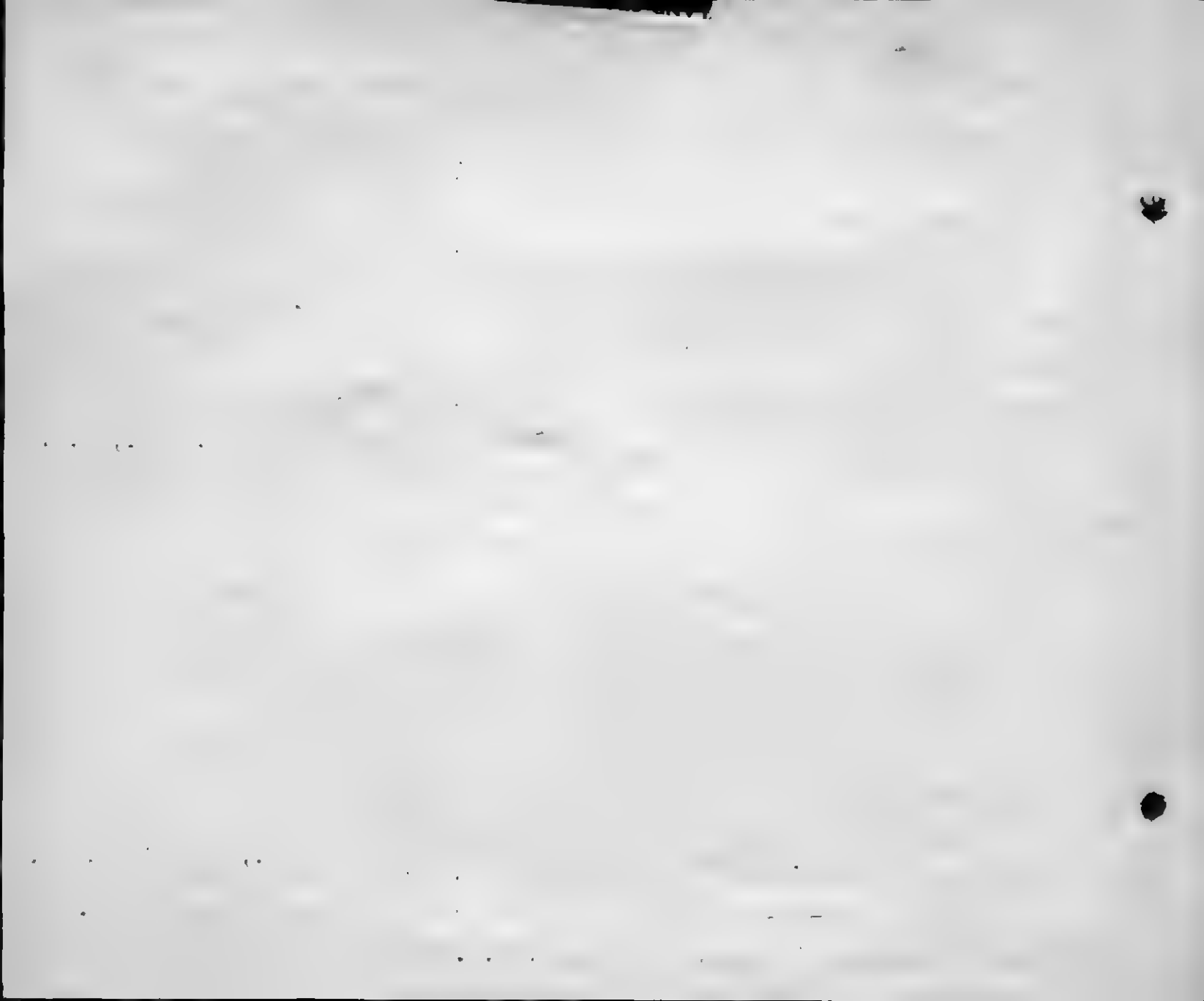
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16903

CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|--------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> c. LENGTH OF STAY in lb <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR - 4922 LA SALLE RD</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>BAKERS STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ethel Robeson STERLING</u> First Middle Last | | | 4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1965</u> | | | | | |
| 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-15-72</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> | | | | |
| 13. FATHER'S NAME <u>George Robeson</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY AULICK</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | | |
| 17. INFORMANT <u>Ethel Davidson</u> Address <u>2224 Wash. Ave., S.S.</u> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO (b) <u>Cerebral atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma breast</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Spring Apr. 1962</u> to <u>10 Dec. 1965</u> that (I) (we) last saw the deceased alive on <u>1 Dec. 1965</u> and that death occurred at <u>2:41 M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Paul T. McPhee</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Paul T. McPhee</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>5201 Randolph Rd., Rockville, Md.</u> 22b. DATE SIGNED _____ | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-13-65</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons</u> | | 24b. ADDRESS <u>Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 16 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16904

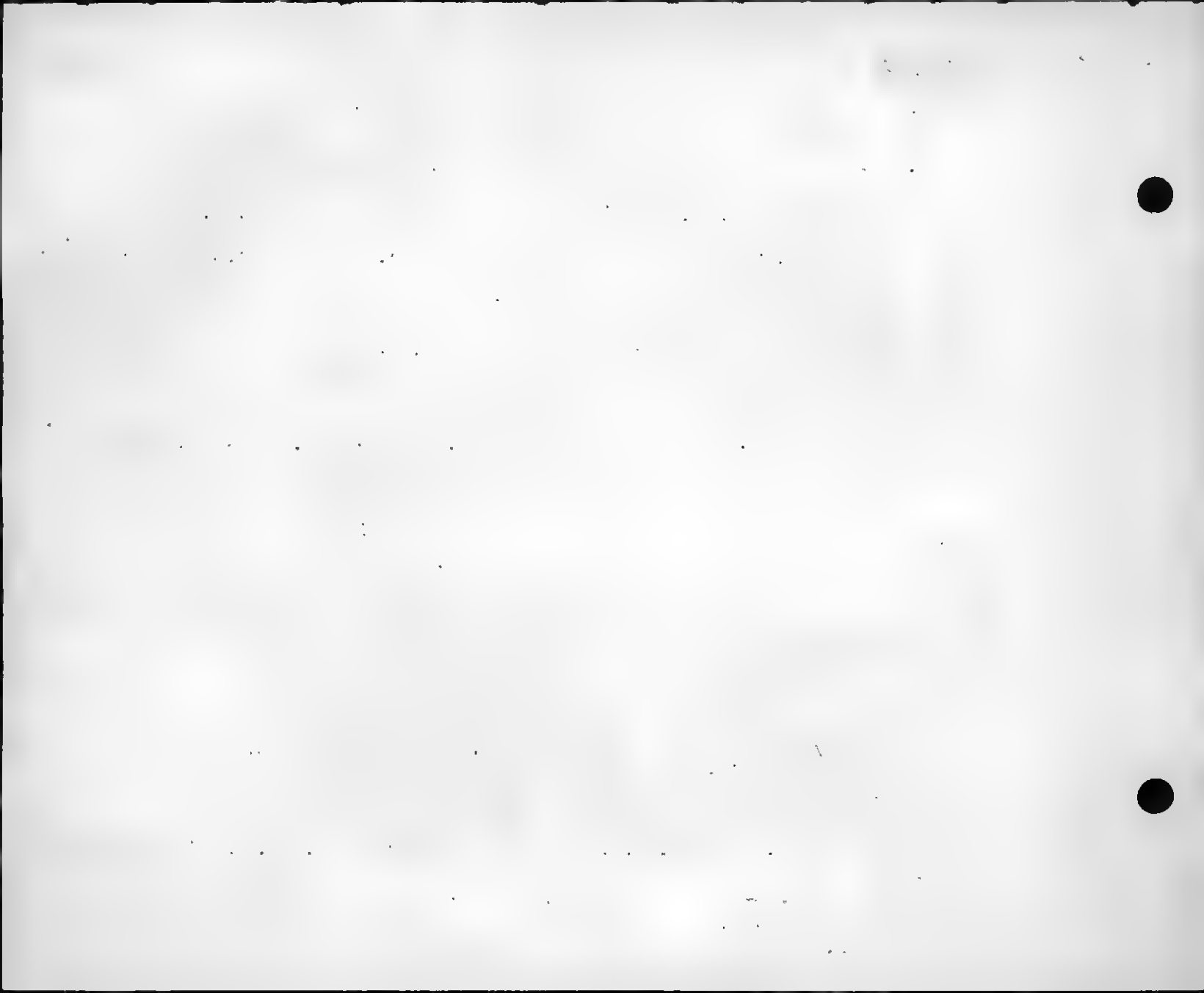
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2885

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN ID <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>507 67th Place, N. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Otha</u> Middle <u>L</u> Last <u>Sterling, Sr.</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>19 65</u> | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/16/94</u> | 9. AGE (In years last birthday) <u>71</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>Amelia ?</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Lanham, Md.</u> <u>Otha L. Sterling Jr. 8701-Crandall Rd</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>thrombophlebitis</u> DUE TO (c) <u>congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 21</u> , 19 <u>65</u> , to <u>Dec. 29</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29</u> , 19 <u>65</u> , and that death occurred at <u>12:20</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Don B. Cameron</u> M.D. | | | | 22b. DATE SIGNED <u>12-29-65</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Don B. Cameron, M.D.</u> | | | | 22d. ADDRESS <u>3503 Perry St. Mt. Rainier, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec. 30-1965</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>1661--Good Hope Rd SE Wash DC</u> | | | | 25a. REC'D BY REGISTRAR <u>JAN 3 1966</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |



1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

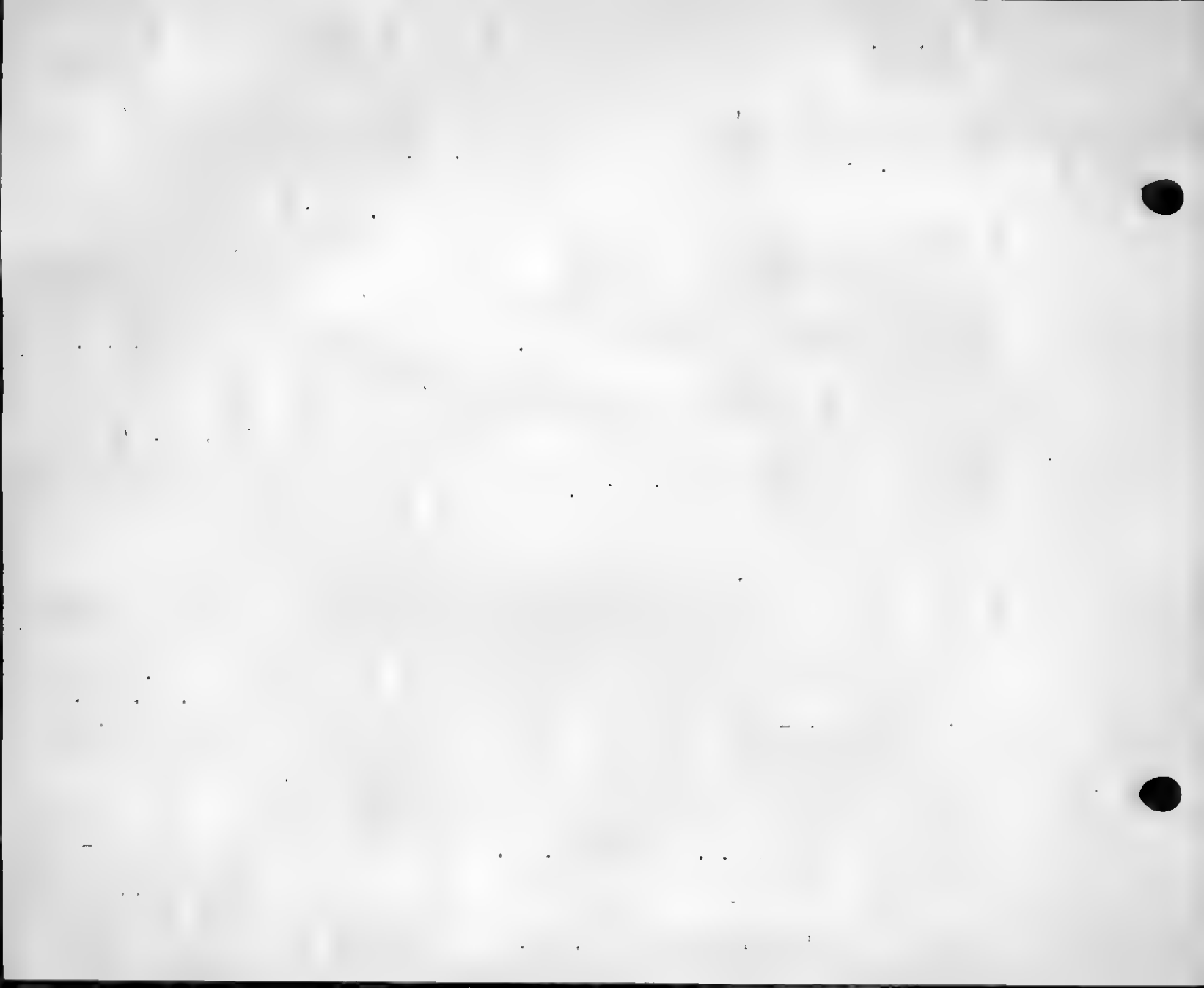
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16505

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. STREET ADDRESS 1223 48th. Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Paul Thomas Swank | | 4. DATE OF DEATH 12 5 1965 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 20, 1939 |
| 9. AGE (In years last birthday) 26 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Mln. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Construction Co. | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Thomas Swank | | 14. MOTHER'S MAIDEN NAME Margaret Gonder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Dorothy Cook | | Address Monroeville, Pa. (sister) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of chest 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off road and hit a tree. | |
| 20c. TIME OF INJURY Month, Day, Year 3:25pm p.m. 12-5-1965 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. CITY OR TOWN Prince Geo. Co., Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-6-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/9/65 | 23c. NAME OF CEMETERY OR PLACE OF BURIAL Hill's Church | 23d. LOCATION (City, town or county) (State) Westmoreland Co., Pa |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons | | 25a. REC'D BY REGISTRAR 1965 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION



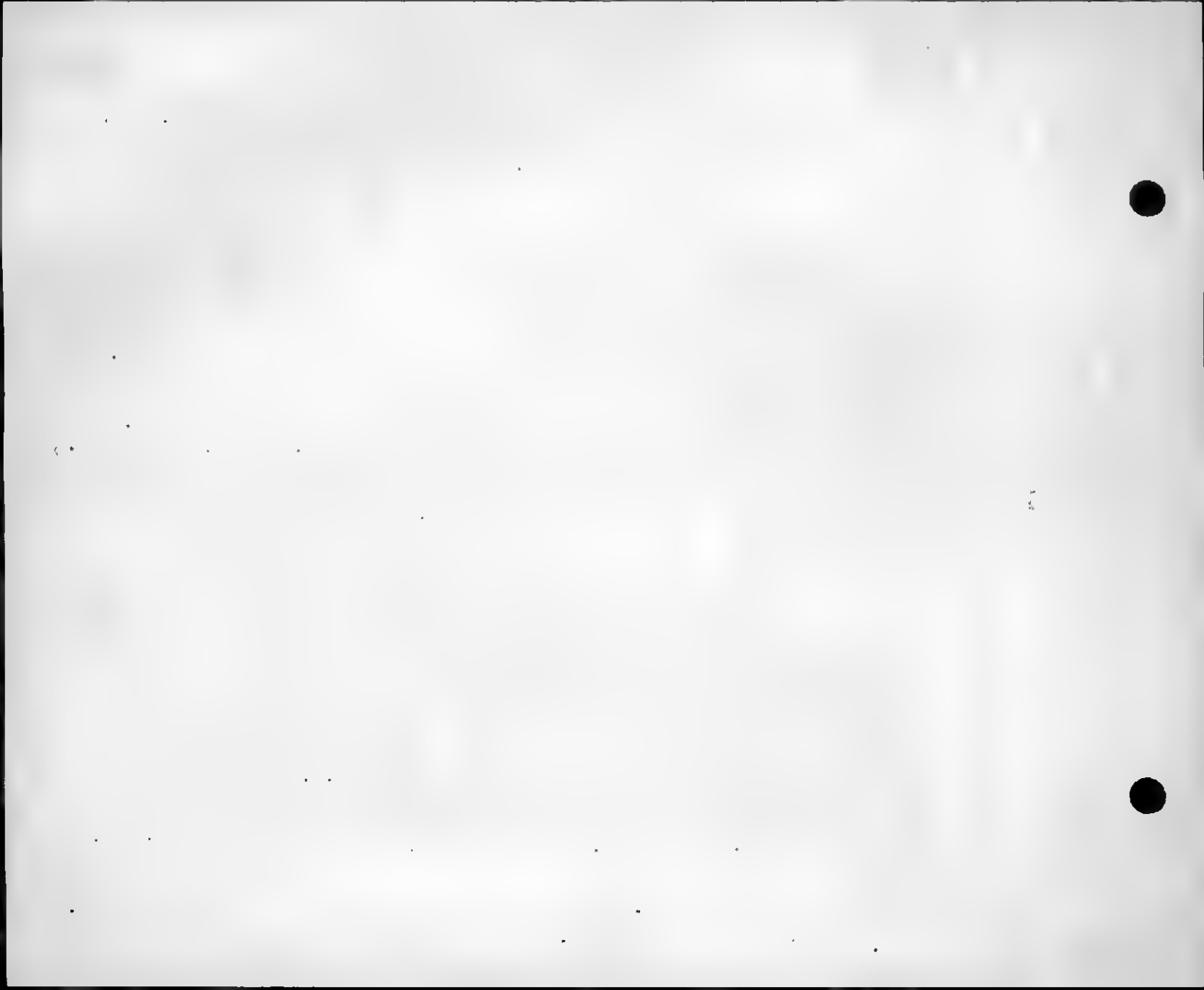
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death.

15M 4-64

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item #7 Film #0372 1/3/66 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 mo-17 da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General HOSPITAL | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Box 1035 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Hammond Middle Swann Last Swann | | | | | | 4. DATE OF DEATH Month Dec Day 25 Year 1965 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1879? | | 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Swann | | | | | | 14. MOTHER'S MAIDEN NAME Mary Estep | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | | 16. SOCIAL SECURITY NO. Croome, Md. | | | | | |
| 17. INFORMANT Chesley Swann Bx.3360 Airport Rd., | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal insufficiency 274X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 3 months | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 65 , to 12/26 , 19 65 , that (I) (we) last saw the deceased alive on 12/23 , 19 65 , and that death occurred 4:00 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Frank J. Talbot | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/27/65 | | | |
| 22c. PHYSICIAN'S NAME (Type) Frank J. Talbot, MD. | | | | | | 22d. ADDRESS 4307 Branch Ave Marlow Heights Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 12-29-65 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Methodist | | 23d. LOCATION (City, town or county) (State) Croome, Md. | | | |
| 24. FUNERAL DIRECTOR Myrtle K. Rollins 4339 Washington N.E. | | | | | | 25a. REC'D BY REGISTRAR DEC 29 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16807

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|
| PLACE OF DEATH a. COUNTY Prince George's | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ida Mae Talhelm | | 4. DATE OF DEATH Month Day Year December 19 1965 | | 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 8. DATE OF BIRTH 1-24-18 | | 9. AGE (in years last birthday) 47 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Smithfield, Penn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Earl Whoolery | | 14. MOTHER'S MAIDEN NAME Donna Dancer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 200-01-68288 | | 17. INFORMANT Sprague Talhelm Jr. | | Address 2504 14th St N.E., Wash, DC | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction and Fibrosis DUE TO (b) Coronary Occlusion, left anterior descending DUE TO (c) Coronary Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | | |
| 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | 22. DATE SIGNED | | Address (Street, city, town, or county) Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 23, 1965 | | 23c. NAME OF CEMETERY OR CREMATORY Hopwood Cemetery | | 23d. LOCATION (City, town or county) (State) Hopwood, Pennsylvania | |
| 24. FUNERAL DIRECTOR Lee FunrHome, | | 25a. REC'D BY REGISTRAR DEC 22 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN ID 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 3C. Plateau Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Adassah Middle Taylor Last Taylor | | | | 4. DATE OF DEATH Month Dec. Day 13 Year 19 65 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 31 May 1895 | | 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 70 Days 0 Hours 0 Min. 0 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY ENGLAND | | | | 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOSEPH SCHIFIELD | | | | | | 14. MOTHER'S MAIDEN NAME SARAH ANN IVES | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT HAROLD TAYLOR (HUSBAND) SAME AS \$2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart failure 4200 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) arterio sclerotic Heart disease DUE TO (c) auricular fibrillation | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Cecum with Liver Metastasis | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 17 , 19 65 , to Dec. 13 , 19 65 , that (I) (we) last saw the deceased alive on Dec. 13 , 19 65 , and that death occurred at 6:40 AM from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Zouheir Shama | | | | | | | | 22b. DATE SIGNED Dec. 13, 1965 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Zouheir Shama, M.D. | | | | | | 22d. ADDRESS Prince George's Genl. Hosp. Cheverly, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 12-15-65 | | 23c. NAME OF CEMETERY OR CREMATORY GEORGE WASH. CEMETERY | | | | 23d. LOCATION (City, town or county) (State) HYATTSVILLE MD. | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS | | | | | | 25a. REC'D BY REGISTRAR DEC 16 1965 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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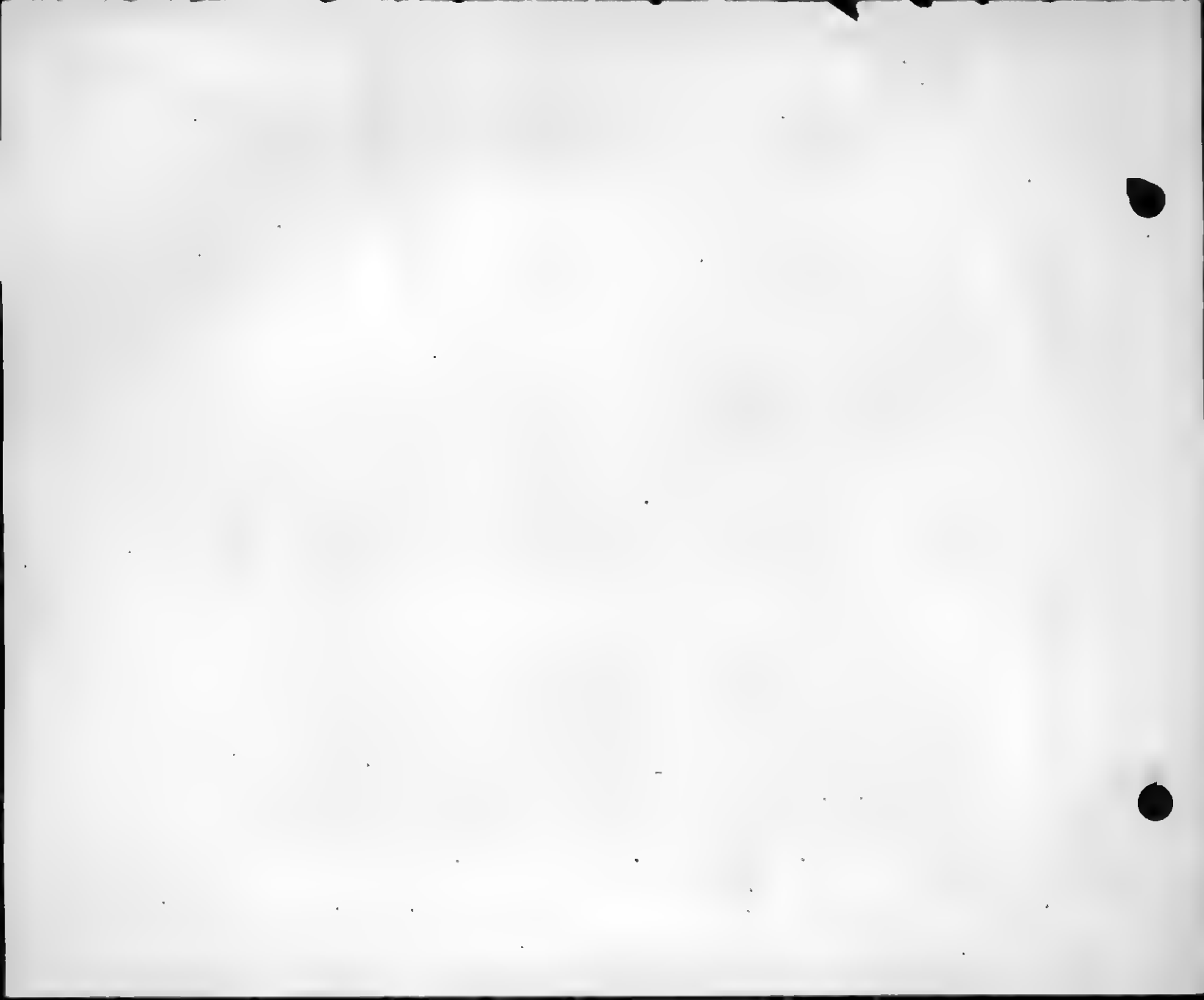
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X College Park d. STREET ADDRESS 5101 Pierce St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Anna Yaroie Taylor | 4. DATE OF DEATH December 23, 19 65 | 5. SEX Female | |
| 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-28-30 | 9. AGE (In years last birthday) 35 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) North Carolina | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charlie Pa Herson | | 14. MOTHER'S MAIDEN NAME Jessie May Turner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Husband/Medical Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of h ovary @ metastasis 1 yr DUE TO (b) uremia - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yr | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-14- , 19 65 , to 12-23- , 19 65 , that (I) (we) last saw the deceased alive on 12-23- , 19 65 , and that death occurred at 10:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE R.C. Herman | | 22b. DATE SIGNED 12-23-65 | |
| 22c. PHYSICIAN'S NAME (Type) R. C. Herman, M. D., 4404 Queensbury Road, Riverdale, Maryland | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12-29-65 | 23c. NAME OF CEMETERY OR CREMATORY Harmony mem Park | 23d. LOCATION (City, town or county) (State) Hyland Park Md |
| 24. FUNERAL DIRECTOR H.S. Washington + Son 4925 Deane Ave NE | | 25a. REC'D BY REGISTRAR DEC 29 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

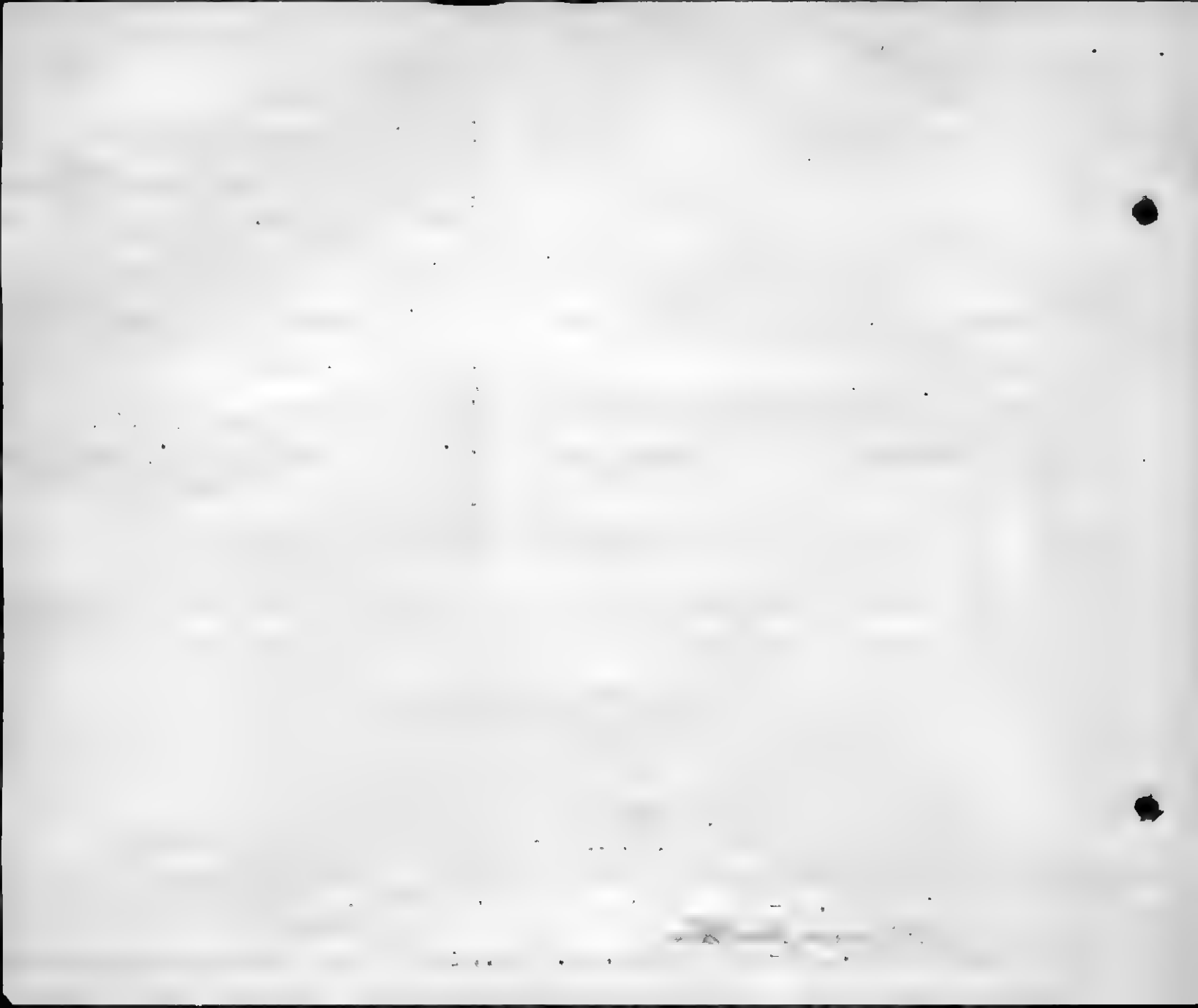


Items 18&21 Film G374
MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
 FOR STATE
 HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. STREET ADDRESS 8100 Oxon Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Retha Lorraine Tennyson | | 4. DATE OF DEATH Month Day Year 12 25 19 65 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 17 June, 1923 |
| 9. AGE (In years last birthday) 42 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (State or foreign country) Georgia |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Clifford Hamilton | |
| 14. MOTHER'S MAIDEN NAME Daisy ? | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no | |
| 16. SOCIAL SECURITY NO. no | | 17. INFORMANT James W. Tennyson Same as # 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 9219 DUE TO Conditions, if any, which gave rise to immediate cause (b) From aspiration of gastric contents (a), stating the underlying cause last. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-25-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec. 28-65 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington | 22d. LOCATION (City, town, or county) (State) Virginia |
| 23. FUNERAL DIRECTOR Simmons Bros. 1661- Good Hope Rd. SE. Wash., DC. | | 24a. REC'D BY REGISTRAR DEC 28 1965 24b. REGISTRAR'S SIGNATURE Charles Judge | |

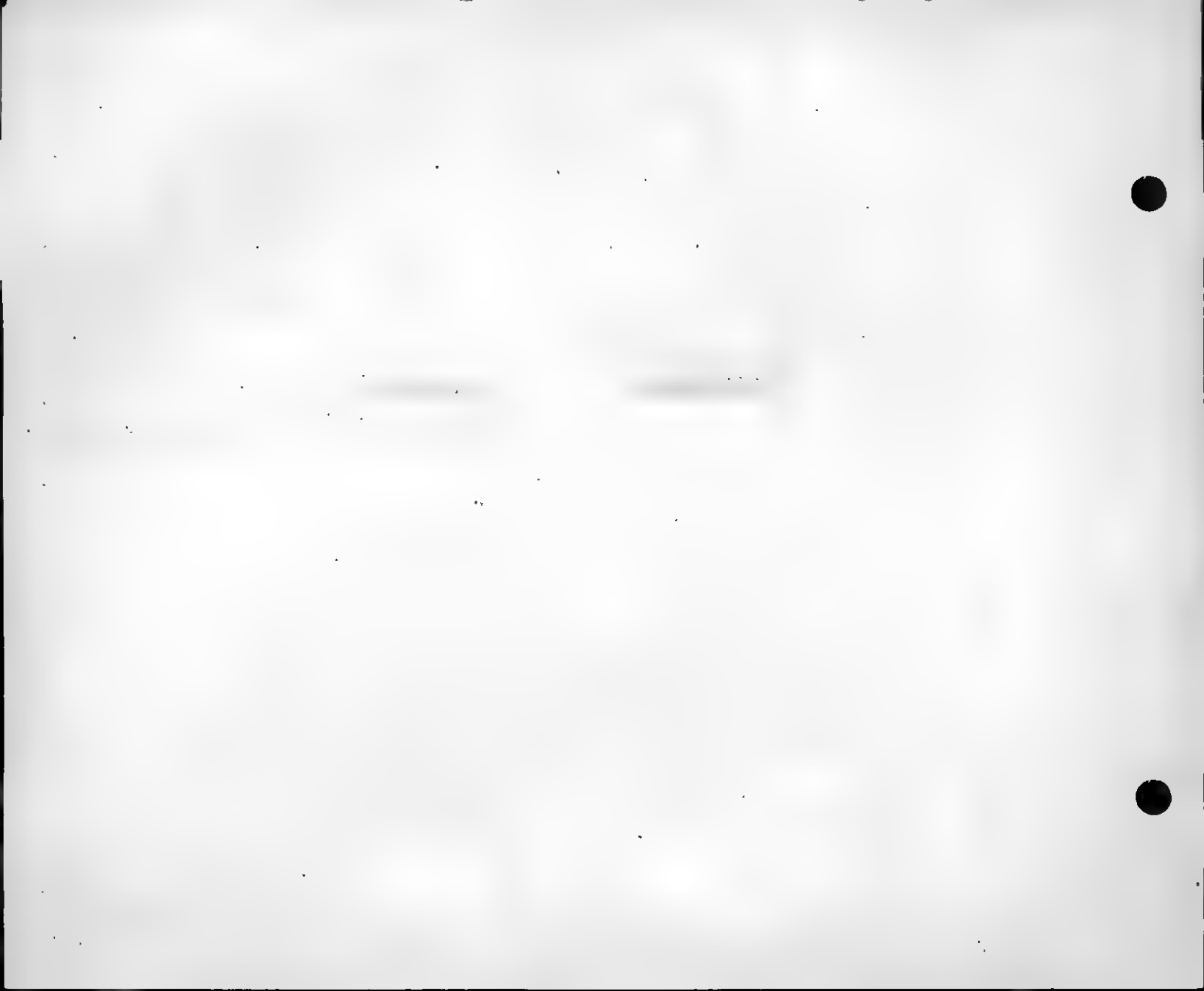


VR A15 (4)
20M 1/65

2

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1293 | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Geo County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale Md c. LENGTH OF STAY IN ID 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Keland Memorial Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Prince Geo c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville Md Apt 102 d. STREET ADDRESS 3900 Hamilton St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) Cassie V. Thomas First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/19/87 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | | | | 4. DATE OF DEATH Dec. 5, 1965 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 13. FATHER'S NAME Daniel P. Proctor 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT 4408 Yeopsbury Rd. Address Riverdale, Md Record Office | | | | | 14. MOTHER'S MAIDEN NAME Mrs. LEBUSA Williams 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1160 OUE TO CARCINOMA OF VULVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 JULY, 1964, to 5 DEC, 1965, that (I) (we) last saw the deceased alive on 5 DEC. 1965, and that death occurred at 12:00 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE C. J. Houmann 22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22b. DATE SIGNED 6 DEC 1965 22d. ADDRESS RIVERDALE MD. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/7/65 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln 23d. LOCATION (City, town or county) (State) Calmar Manor Md. 24. FUNERAL DIRECTOR Francis Hersch Sons Hyattsville, Md. 25a. REC'D BY REGISTRAR DEC 8 1965 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

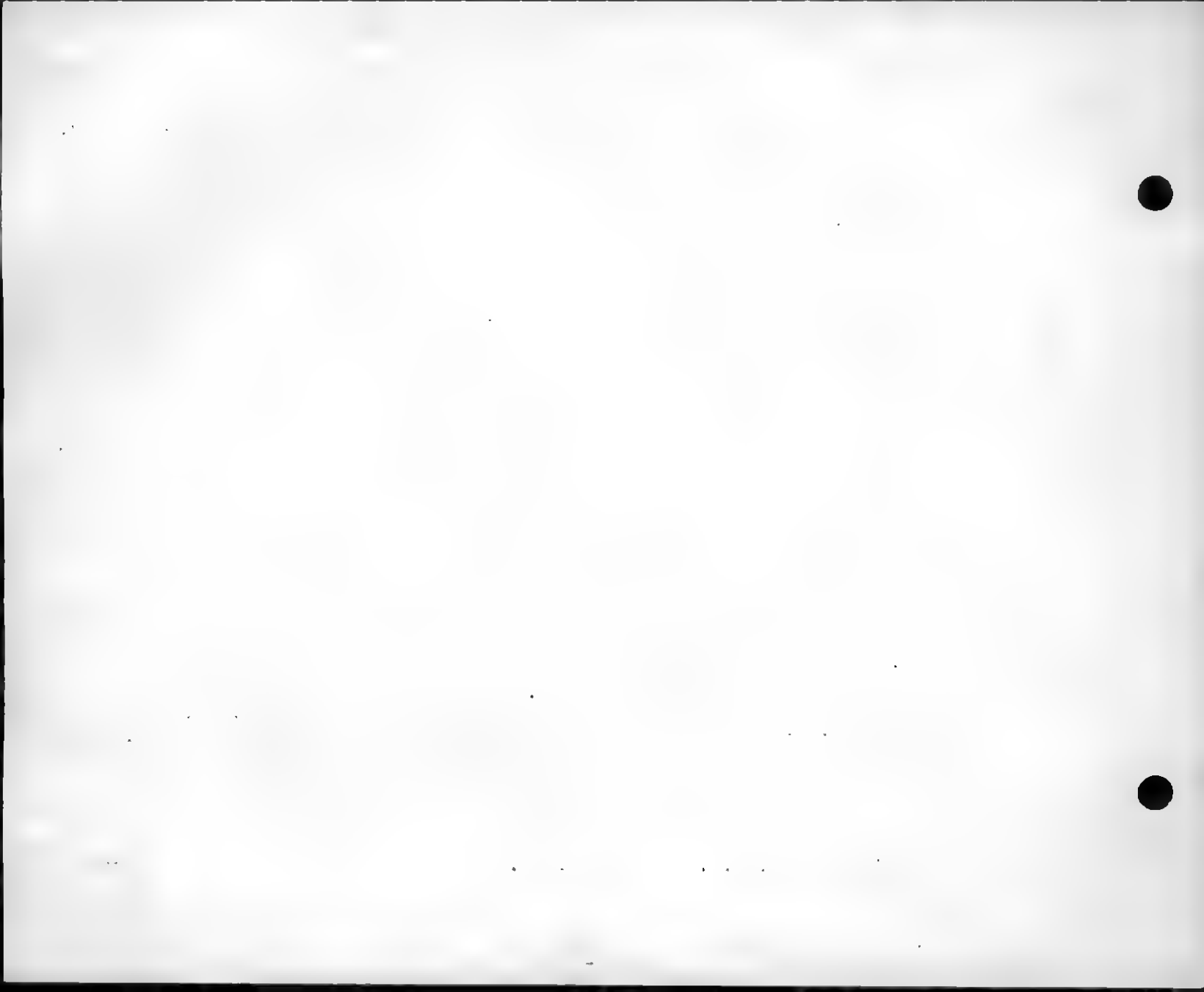
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1965

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George's | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | f. STREET ADDRESS 7232 Joplin Street | |
| 3 NAME OF DECEASED (Type or print) Clement Alan Thornton | | 4 DATE OF DEATH Month 12 Day 30 Year 1965 | |
| 5 SEX Male | 6 COLOR OR RACE Negro | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-5-1959 |
| 9. AGE (In years last birthday) 6 yrs | | 10. IF UNDER 1 YEAR Months 12 Days 30 | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME James Leo Thornton | | 14. MOTHER'S MAIDEN NAME Marcia | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT James Thornton-7232 Joplin Street | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8124 IMMEDIATE CAUSE (a) Multiple injuries DUE TO Fracture of both femora and mandible Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) And laceration of brain DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by car. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:55pm p.m. 12-30-1965 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Pleasant, Md. (County) (State) | | 20f. (City or town) 6900 block of George Palmer Highway, Seat | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-31-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1/4/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home 4001 Benning Road, | | 25a. REC'D BY REGISTRAR NE | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 5 1966 | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16913

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights d. STREET ADDRESS 5118 Logan Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Dorothy L Tucker 4. DATE OF DEATH 12 4 19 65 | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 12-31-1906 9. AGE (In years last birthday) 58 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 10b. KIND OF BUSINESS OR INDUSTRY T. Paul Mudd Real Estate Co. 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? New York | |
| 13. FATHER'S NAME Daniel Paton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Albert Blair Tucker 5419- Auth Rd. SE. | | 14. MOTHER'S MAIDEN NAME Ruby Blair Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) Coronary artery occlusion DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH minutes unknown | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. 22. DATE SIGNED 12-6-65 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Dec. 7-1965 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (city, town or county) (State) Suitland, Maryland | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

Item 20 Film G375 4/ MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles County | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf | |
| c. LENGTH OF STAY IN 1b 8 days | | d. STREET ADDRESS RFD 1, Box 152 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clarence Arthur Turner | | 4. DATE OF DEATH Month 12 Day 25 Year 19 65 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-31-1885 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | 11. BIRTHPLACE (State or foreign country) Prince George's, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Georgianna Yates | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO 217-32-2265 | | 17. INFORMANT Roland Turner - R.F.D. 1 - Box 152 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 12/17 19 65 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barn on farm | |
| 20f. (City or town) Waldorf | | (County) Charles (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | |
| SIGNATURE John Kehoe, M.D. | | DATE SIGNED 12-27-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-29-65 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Phillips Ep. Ch. Cem. | | 22d. LOCATION (City, town, or county) Aquasco, Md. | |
| 23. FUNERAL DIRECTOR Martell Adams | | 24a. REC'D BY REGISTRAR JAN 3 1966 | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

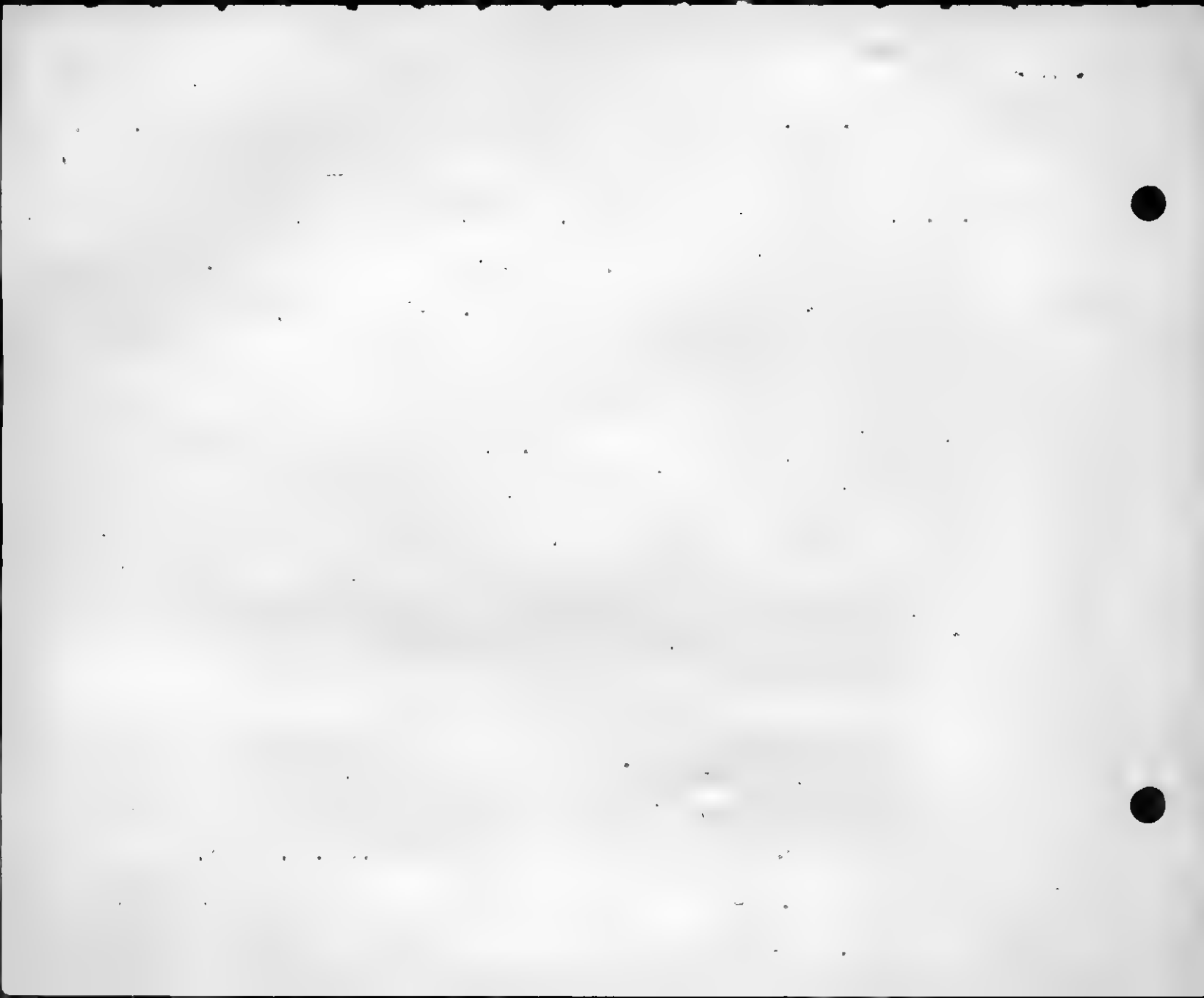
16915

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Pr. Geo. MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1D X Bel Air -- Bowie | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. O. A. Prince George General Hosp. | | | d. STREET ADDRESS 12192 Maddox Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) EVA | First EVA | Middle L. | Last TWILLEY | 4. DATE OF DEATH Dec. 7th 1965 | Day 7th Year 1965 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 24-1895 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months Oays Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 13. FATHER'S NAME Joseph Poe | | | 14. MOTHER'S MAIDEN NAME Hattie Potter | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT A. June Philyaw Address Same as Item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Cerebral Thrombosis (b) Cerebral Arteriosclerosis DUE TO Cerebral Arteriosclerosis (c) Diabetes Mellitus, Hypertension, Rheumatoid Arthritis | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 HOUR 2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Hypertension, Rheumatoid Arthritis | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from June , 19 60 , to Dec 5 , 19 65 , that (I) (was) last saw the deceased alive on 5 Dec 1965 , and that death occurred at 9:05 A.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Jack Crowell MD | | | 22b. DATE SIGNED Dec. 7-1965 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Jack Crowell | | | 22d. ADDRESS 2025-I-St., N. W. Wash. DC | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 10-1965 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION (City, town or county) Suitland, Maryland | | (State) | | | |
| 24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC | | | 25a. REC'D BY REGISTRAR DEC 9 1965 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge |

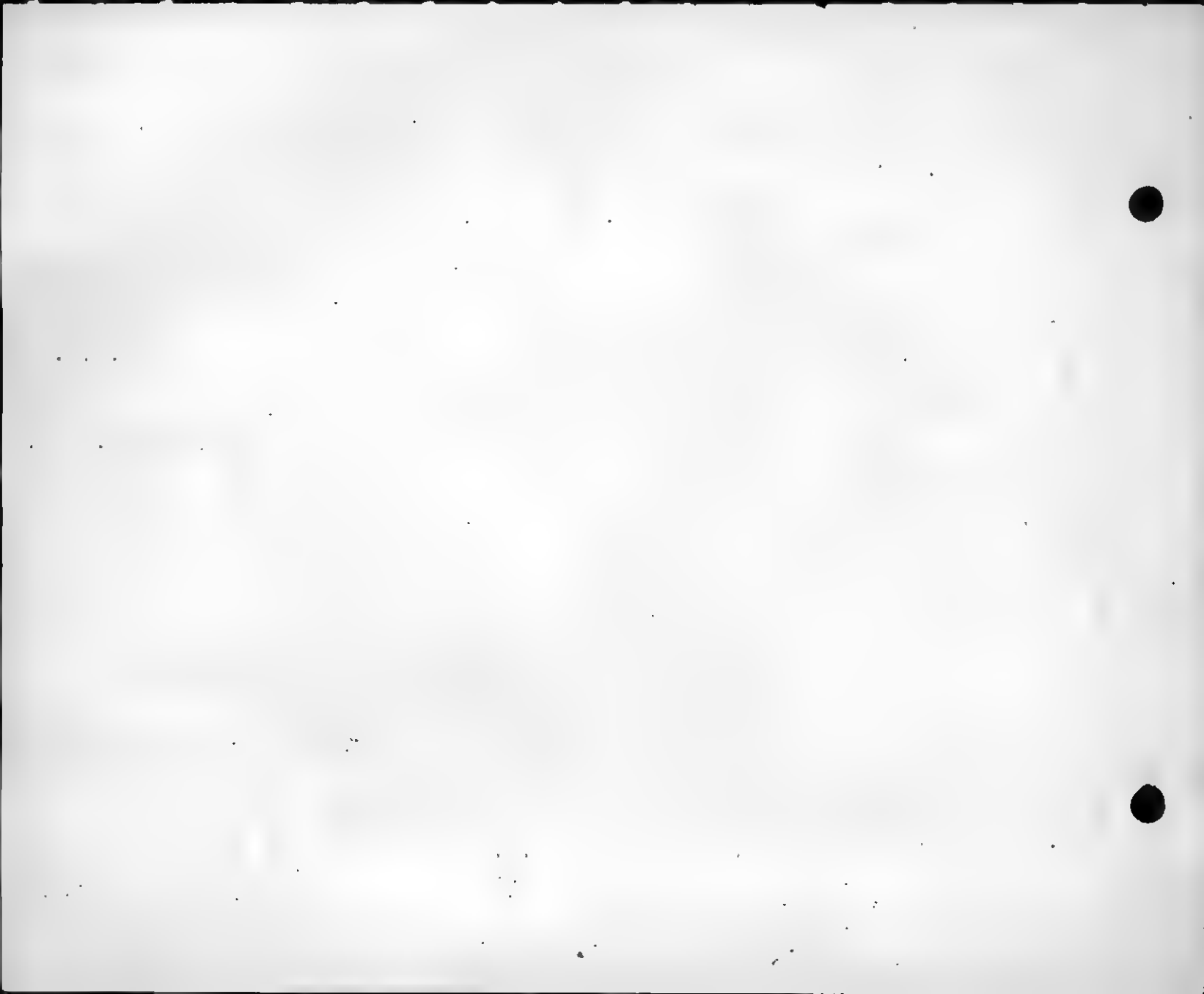


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
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| 16916 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland | | | | | | | | | | | |
| c. LENGTH OF STAY IN 1b 8 Days | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suitland Nursing Home, Inc. | | | | | | | | | | | |
| 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | | | | | | | | |
| b. COUNTY Prince Georges | | | | | | | | | | | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland | | | | | | | | | | | |
| d. STREET ADDRESS 4629 Lewis Ave. | | | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Caetano Middle Vitale Last | | | | | | | | | | | |
| 4. DATE OF DEATH December 3, 19 65 | | | | | | | | | | | |
| 5. SEX M | | | | | | | | | | | |
| 6. COLOR OR RACE W | | | | | | | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | |
| 8. DATE OF BIRTH 11-16-1885 | | | | | | | | | | | |
| 9. AGE (In years last birthday) 80 yrs. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | | | | | | | | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Italy | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME Joseph Vitale | | | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME Rachel Aversa | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | | |
| 16. SOCIAL SECURITY NO. 163-05-3301 | | | | | | | | | | | |
| 17. INFORMANT Joseph Vitale 2103 Liner Street Hillcrest Hgts., Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 week | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 19 65 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1965, to Dec. 3, 1965, that (I) (we) last saw the deceased alive on Dec. 2, 1965, and that death occurred at 7:45 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Frank J. Pellegrini M.D. | | | | | | | | | | | |
| 22b. DATE SIGNED 12.3.65 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Frank J. Pellegrini, M.D. | | | | | | | | | | | |
| 22d. ADDRESS 3611 Branch Ave SE | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12-6-65 | | | | | | | | | | | |
| 23b. DATE THEREOF | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) Suitland Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DEC 8 1965 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

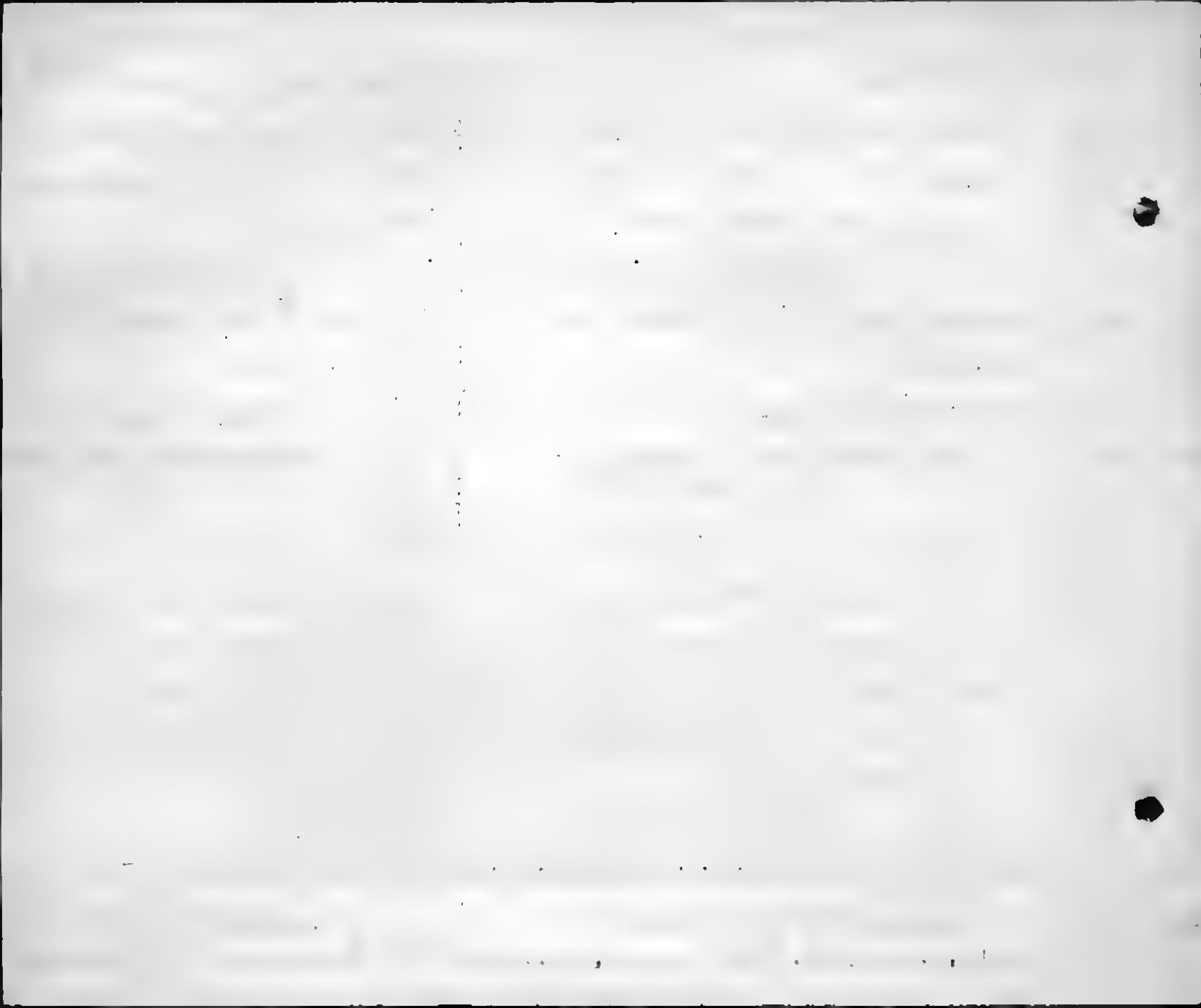
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

199

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 7842 Circle Drive | | | |
| 3. NAME OF DECEASED (Type or print) Efrosene G. Vougioukles | | | | 4. DATE OF DEATH 12 13 19 65 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 22, 1880 | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Sparta, Greece | | | | 12. CITIZEN OF WHAT COUNTRY? Greece | | | |
| 13. FATHER'S NAME Vasili Kavokas | | | | 14. MOTHER'S MAIDEN NAME Staraula Kavokas | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. --- | | | |
| 17. INFORMANT Helen L. Mamakos-511-3rd St. SE DC3 | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | M.D. | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) 12-13-65 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/16/65 | | 22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland | |
| 23. FUNERAL DIRECTOR Jas. T. Ryan, Inc. | | | | ADDRESS 317 Pa. Ave., SE DC | | | |
| 24a. REC'D BY REGISTRAR 16 1965 | | | | 24b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

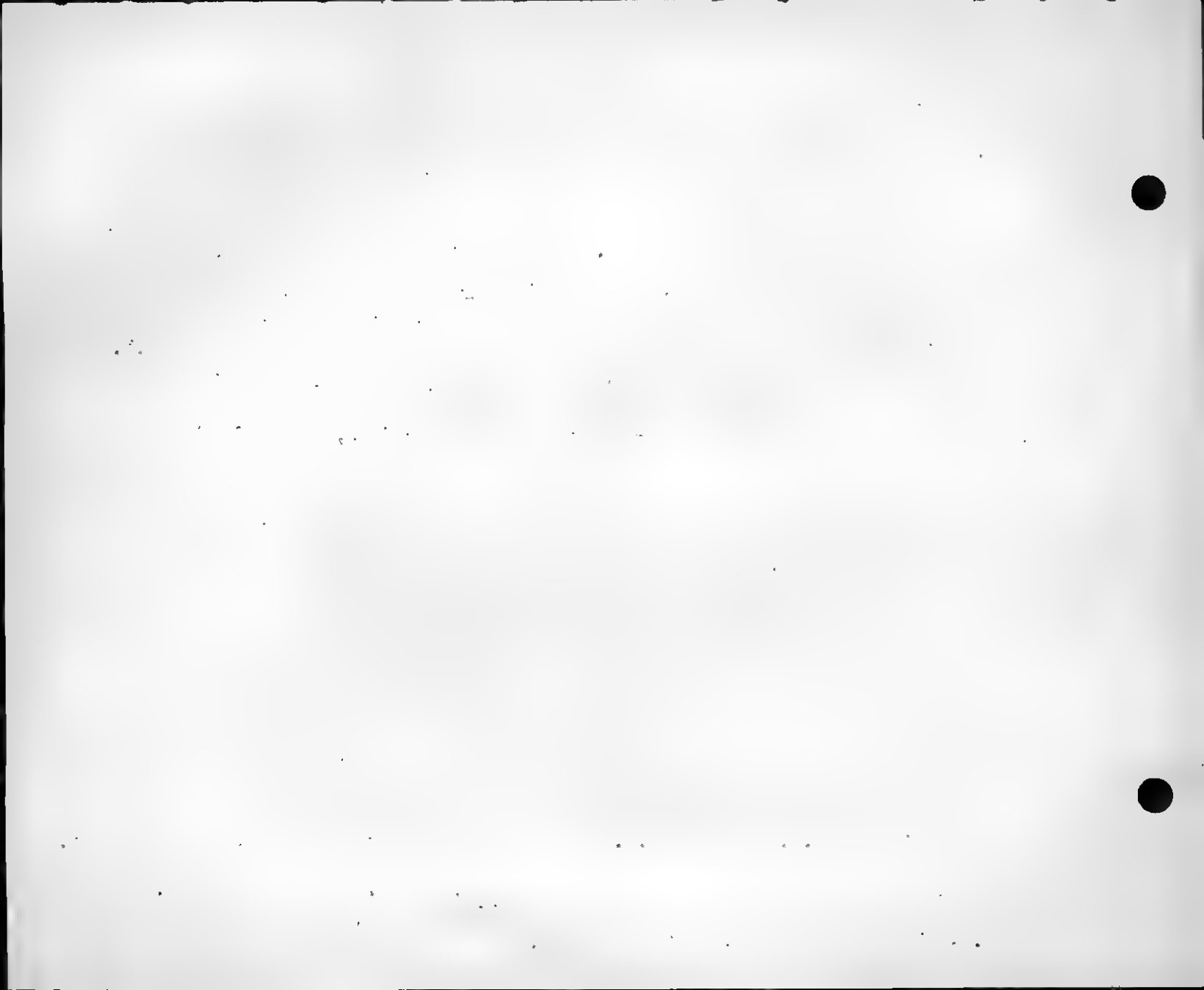
16918

CERTIFICATE OF DEATH

300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

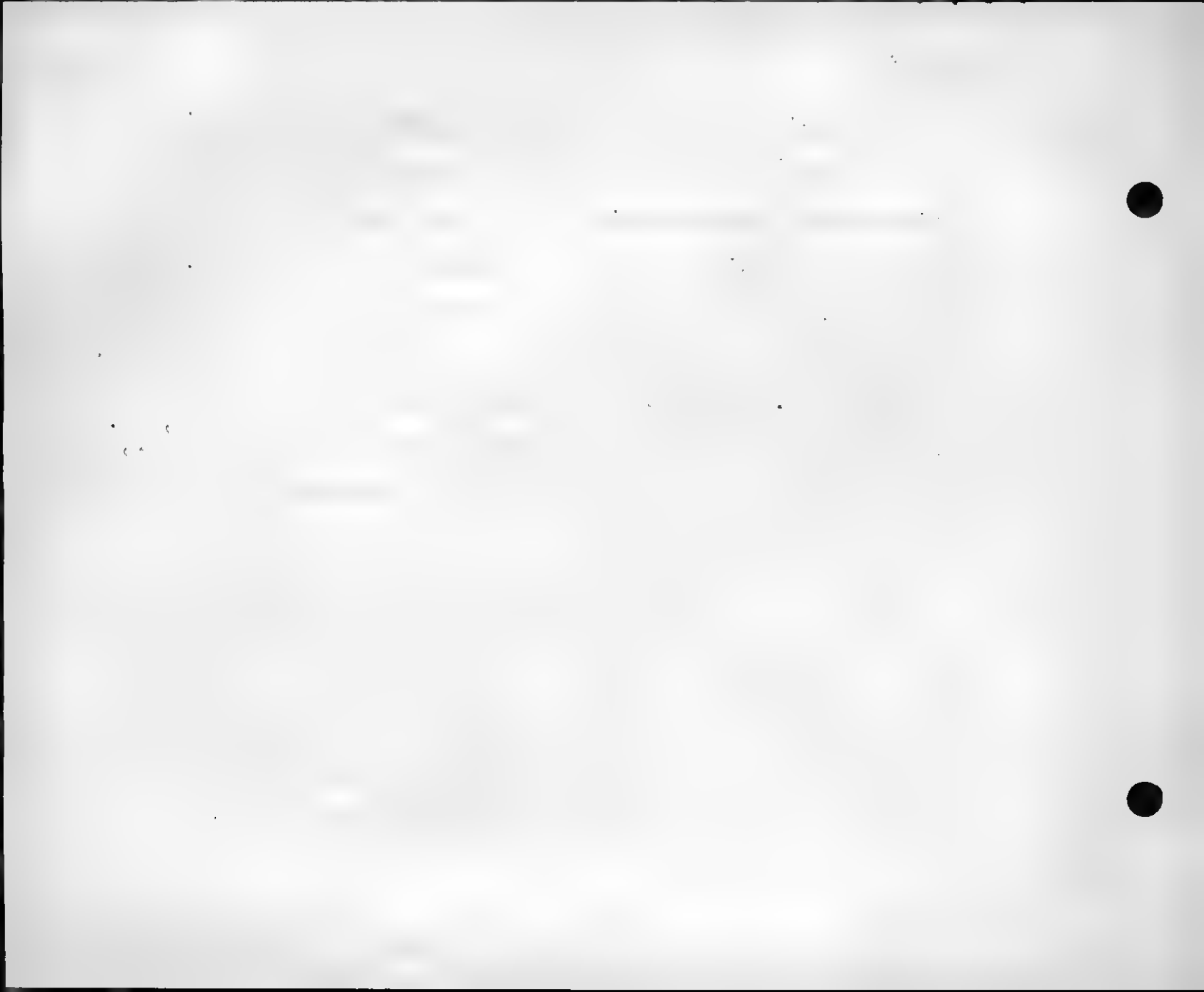
| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5491 Sunnyside Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Ella - Ellen J. Middle J. Last Warden | | 4. DATE OF DEATH Month 12 Day 7 Year 1965 | | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-9-1883 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) U.S. | | | |
| 13. FATHER'S NAME Devers | | | 14. MOTHER'S MAIDEN NAME -- Fuller | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 578-26-3811 | | 17. INFORMANT Lovell Mortfeld, Friend/Medical Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE 4201 DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5 DEC. 1965 to 7 DEC. 1965 , that (I) (we) last saw the deceased alive on 7 DEC. 1965 , and that death occurred at 2:45 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE C.J. Houmann | | | 22b. DATE SIGNED 7 DEC. 65 | | | | |
| 22c. PHYSICIAN'S NAME (Type) C.J. Houmann, M.D. | | | 22d. ADDRESS 4404 Queensbury Road, Riverdale, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-10-65 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Ceme. | 23d. LOCATION (City, town or county) (State) Arlington, Va. | | | | |
| 24. FUNERAL DIRECTOR Stalder Funeral Home | | | 25a. REC'D BY REGISTRAR DEC 10 1965 | | | | |
| | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 16919 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holly Park d. STREET ADDRESS 1206 Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) William | | | First William | | Middle Washington | | Last Washington | | 4. DATE OF DEATH Month Dec. Day 23 Year 19 65 | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-10-88 | | 9. AGE (in years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 77 Days 77 IF UNDER 24 HRS. Hours 77 Min. 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William J. Washington | | | | | | 14. MOTHER'S MAIDEN NAME Catherine UKN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Huntsville, Md. Leo Washington 1206 Hill Rd., | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4200 DUE TO Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute gastrointestinal bleeding | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-19 , 19 65 , to 12-23 , 19 65 , that (I) (we) last saw the deceased alive on 12-23 , 19 65 , and that death occurred at 5:25 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Don B. Cameron | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22b. DATE SIGNED 12-24-65 | | | | | | 22c. PHYSICIAN'S NAME (Type) DON B. CAMERON | | | | | |
| 22d. ADDRESS 3503 PERRY STREET, N.W., D.C. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 12-24-65 | | 23c. NAME OF CEMETERY OR CREMATORY Int. Olivet | | | | 23d. LOCATION (City, town or county) (State) Washington D.C. | |
| 24. FUNERAL DIRECTOR Myrtle K. Rollins | | | | | | ADDRESS 4334 Hunt Pl. N.E. Wash., D.C. | | 25a. REC'D BY REGISTRAR DATE DEC 29 1965 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



1
FOR STATE
HEALTH DEPT.

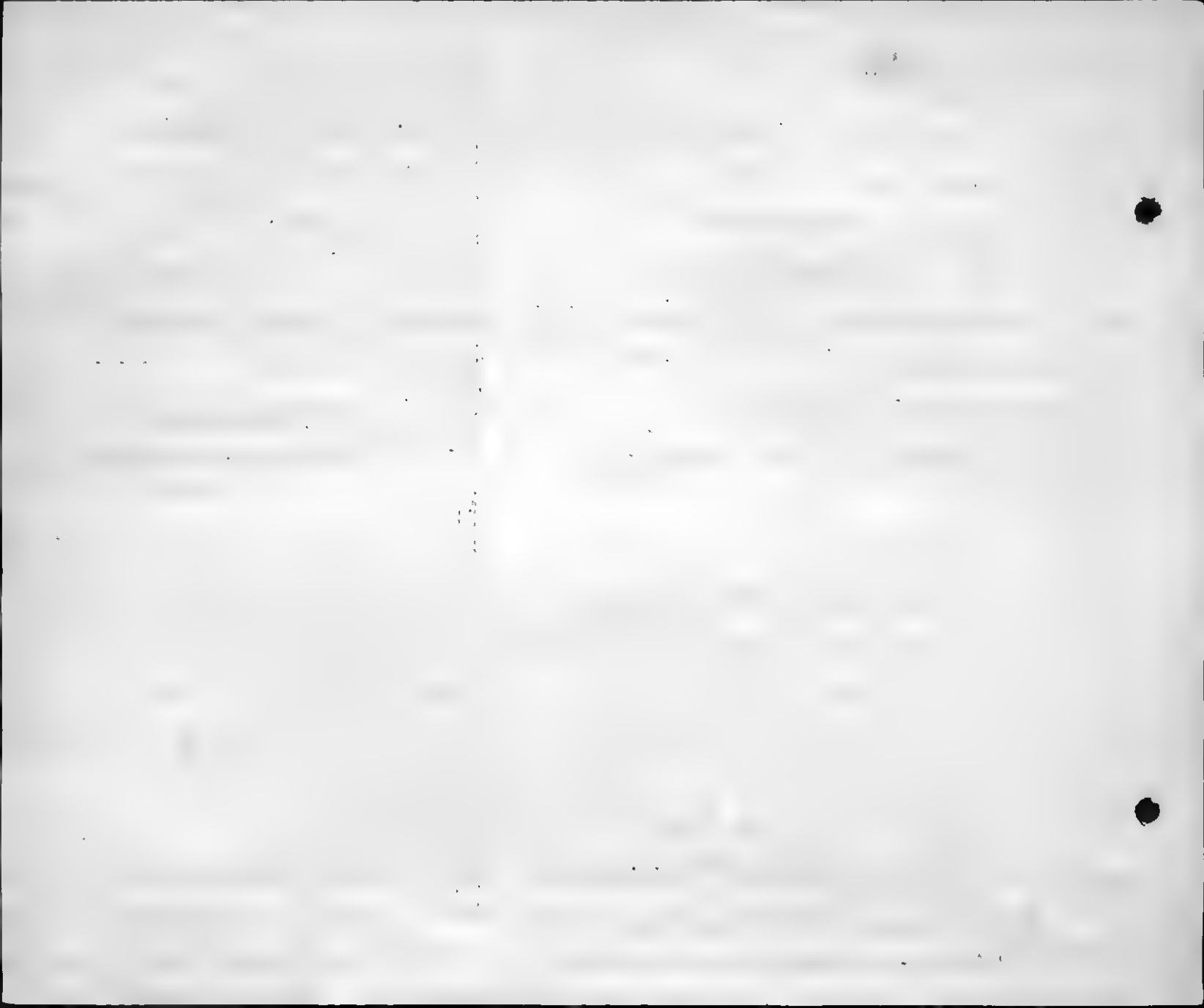
16920

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

202

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|-----------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 9177 Market Lane | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Theresa Whalen | | | | 4. DATE OF DEATH Month Day Year 12 24 19 65 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 25 July, 1908 | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bookkeeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY Galludet College | | | |
| 11. BIRTHPLACE (State or foreign country) New York | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13. FATHER'S NAME Simon J. Shea | | | | 14. MOTHER'S MARDEN NAME Julia Kelly | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 16a | | | |
| 17. INFORMANT Thomas J. Whalen | | | | Address 9177 Market Lane Greenbelt, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis 250.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Osteomyelitis of skull (c), stating the underlying cause last. DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH days 10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED 12-25-65 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 12-22-65 | | 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) Silver Spring, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR Harry E. Humphrey, Inc. | | | | ADDRESS 24 Georgia Avenue Silver Spring, Md. | | 24a. REC'D BY REGISTRAR JAN 4 1966 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

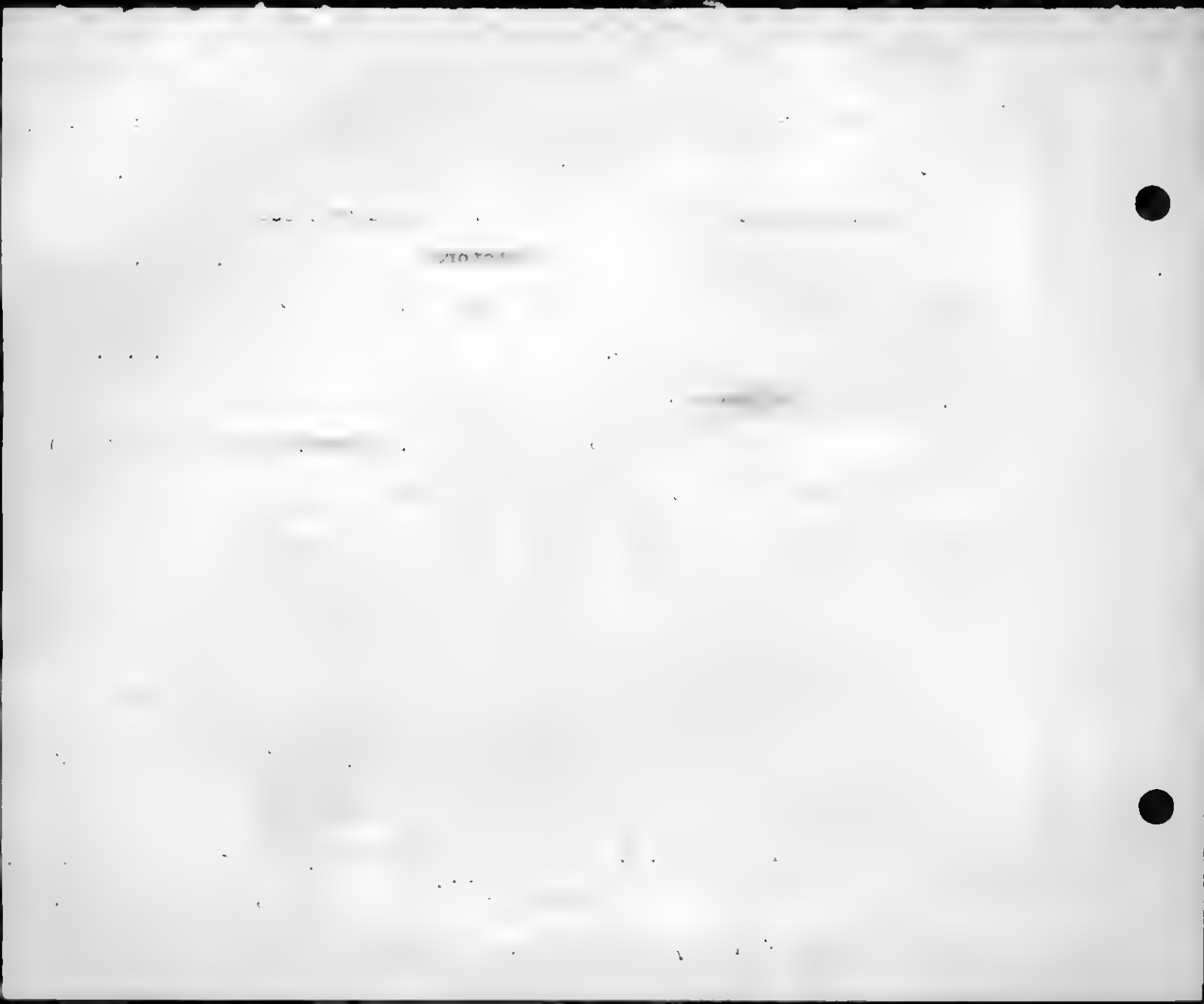


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------|
| 16521 CERTIFICATE OF DEATH 303 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi | | | c. LENGTH OF STAY IN MD 10 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2203 Apache Streett | | | | | d. STREET ADDRESS 2203 Apache Streett | | | | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle CLAY Last Whiteford | | | | | 4. DATE OF DEATH Month DEC. Day 5, Year 1965 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 26, 1901 | | 9. AGE (In years last birthday) 63 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10b. KIND OF BUSINESS OR INDUSTRY Gas Co. | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME W. MORGAN Whiteford | | | | | 14. MOTHER'S MAIDEN NAME ALICE SCARBOROUGH | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 214 01 0316 | | 17. INFORMANT Isabelle S. Whiteford Same as #2 (wife) | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO (b) Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-1, 1934, to 12-5, 1965, that (I) (we) last saw the deceased alive on 12-3, 1965, and that death occurred at M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE A. Deitz | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-6-65 |
| 22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D. | | | | | 22d. ADDRESS Prince George Plaza Hyattsville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/8/65 | | 23c. NAME OF CEMETERY OR CREMATORIUM SLATEVILLE | | 23d. LOCATION (City, town or county) (State) Delta, Pa. | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DEC 8 1965 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

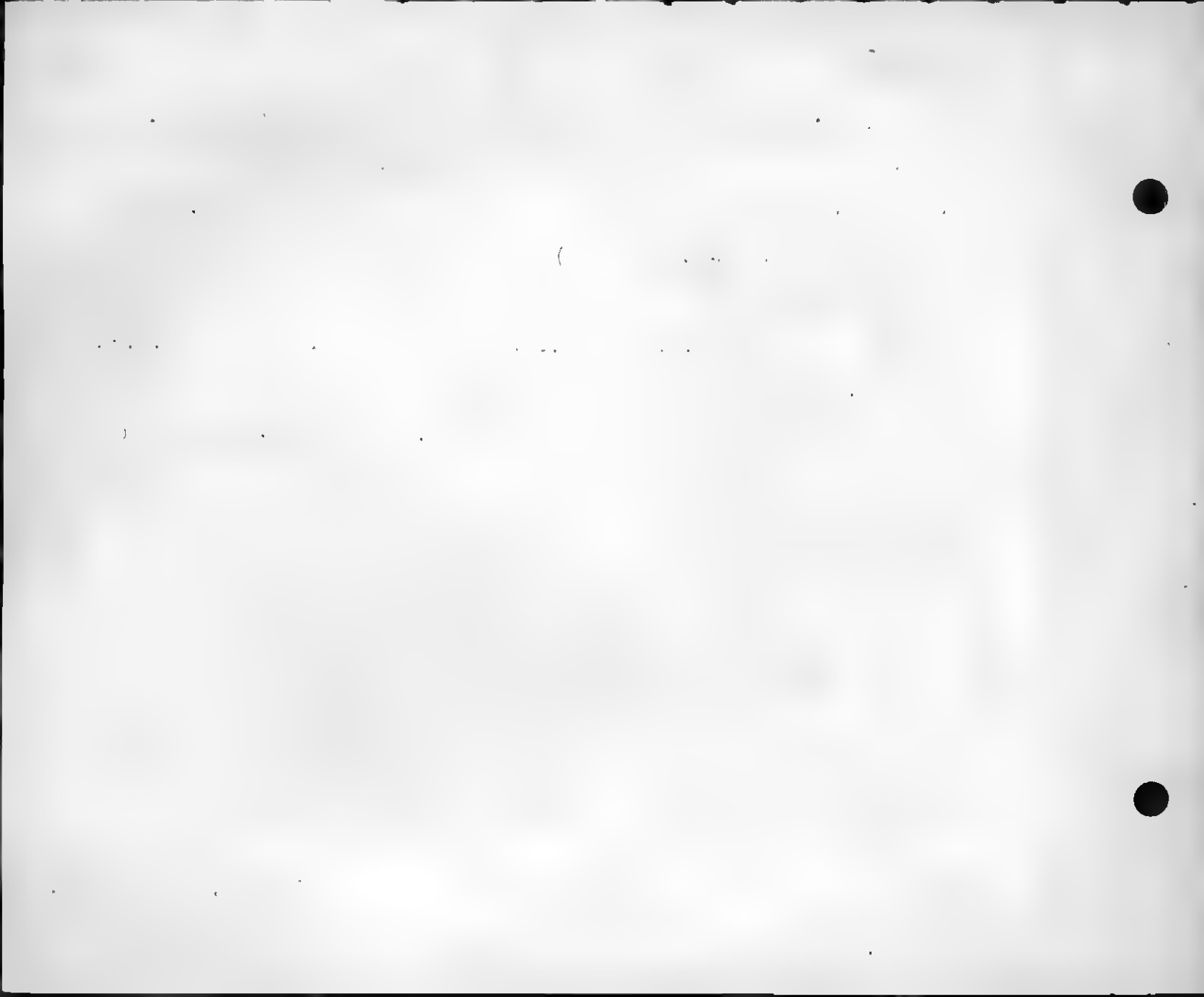


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16922
CERTIFICATE OF DEATH

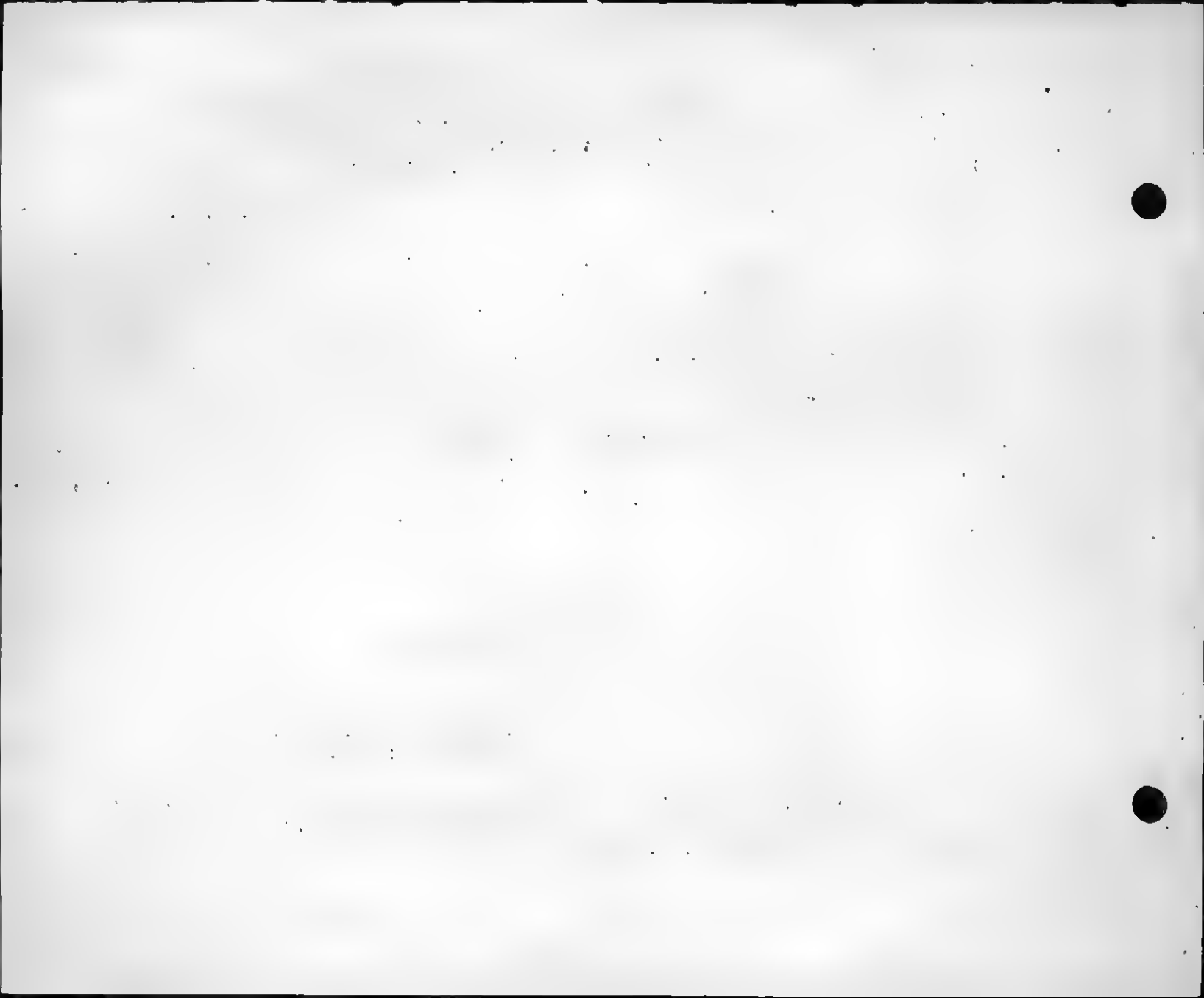
| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5309 38th Avenue Apt. #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Frederick (nmn) Williams | 4. DATE OF DEATH Month 12 Day 5 Year 19 65 | 5. SEX Male | |
| 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-23-95 | 9. AGE (In years last birthday) 69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanic | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles L. Williams | |
| 14. MOTHER'S MAIDEN NAME Mary Barusick | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | |
| 16. SOCIAL SECURITY NO. 577 58 9198 | | 17. INFORMANT Marie A. Williams Same as #2 (wife) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LUNG 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from JULY , 19 65 to DEC 5 , 19 65 , that (I) (we) last saw the deceased alive on 12-5 , 19 65 , and that death occurred at 1:15 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Albert Roth, M.D. | | 22b. DATE SIGNED 12-6-65 | |
| 22c. PHYSICIAN'S NAME (Type) Albert Roth, M.D. | | 22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/9/65 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington, Va. |
| 24. FUNERAL DIRECTOR F. Haskins | | 25a. REC'D BY REGISTRAR DEC 8 1965 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | | | c. LENGTH OF STAY IN 1b 3 years, 3 mos., 23 dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | | | | d. STREET ADDRESS 1117 New Jersey Ave. S. E. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Milton A. Williams | | | | | 4. DATE OF DEATH Month Day Year Dec. 22 1965 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4.17.1918 | | 9. AGE (in years last birthday) 47 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer | | 10b. KIND OF BUSINESS OR INDUSTRY D. C. Sewer Dept. | | 11. BIRTHPLACE (County & State, or foreign country) Macon, Georgia | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Ernest Williams | | | | | 14. MOTHER'S MAIDEN NAME Anna Adams | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 578-16-5157 | | 17. INFORMANT Decedent | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ OUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs, 4 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/29/62 to 12/22, 1965, that (I) (we) last saw the deceased alive on 12/22 1965, and that death occurred at 6:10 P.M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/22/65 | | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12/28/1965 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK | | 23d. LOCATION (City, town or county) (State) LANDOVER MARYLAND | | | |
| 24. FUNERAL DIRECTOR W. ERNEST JARVIS CO. 1432 YOUNG ST. N.W. WASH. | | | | | 25a. REC'D BY REGISTRAR DEC 28 1965 | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | |



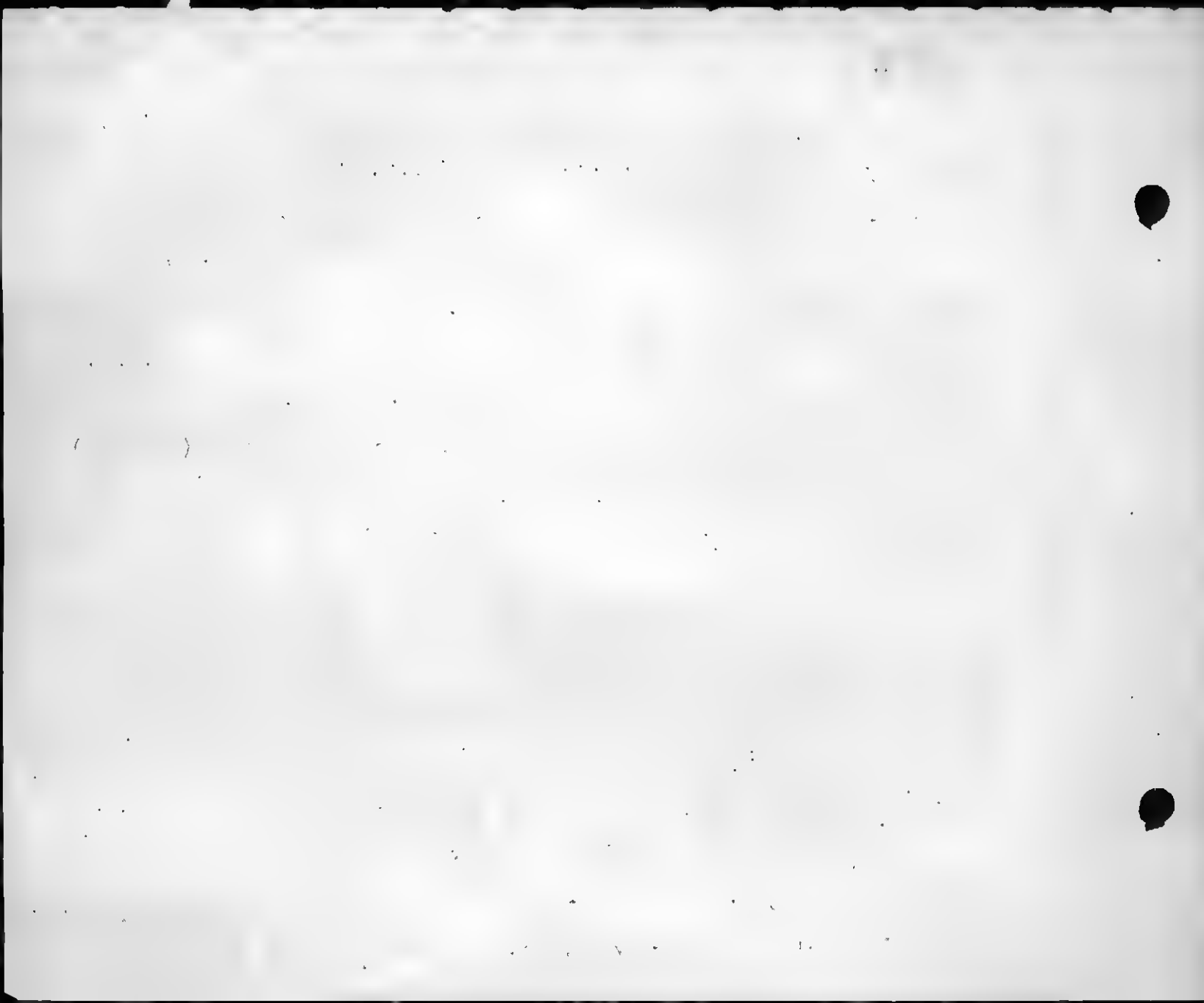
Dr. John Kehoe, deputy medical examiner,
notified and approved.

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16924

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Riverdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 5426 67th Avenue | |
| 3. NAME OF DECEASED (Type or print) Helen Winklerek | | 4. DATE OF DEATH Month Dec. 2, Day 19 Year 65 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1895 |
| 9. AGE (in years last birthday) 70 yrs. | | IF UNDER 1 YEAR: Months 0 Days 0 Min. 0 IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jacob Mossner | | 14. MOTHER'S MAIDEN NAME Mary Zimmerman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Edith A. Cizek Same as #2 (daughter) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 4331 DUE TO (b) Curricular fibrillation & clots - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 30, 1965 to Dec. 2, 1965 , that (I) (we) last saw the deceased alive on Dec. 1, 1965 , and that death occurred at 5 PM , from the causes and on the date stated above. 22a. SIGNATURE Frank R. Shea M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/2/65 22c. PHYSICIAN'S NAME (Type) FRANK R. SHEA 22d. ADDRESS 4100 - 22nd N.E., Wash DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/6/65 | |
| 23c. NAME OF CEMETERY OR CREMATOR Lutheran | | 23d. LOCATION (City, town or county) (State) Middle Village N. Y. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 6 1965 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

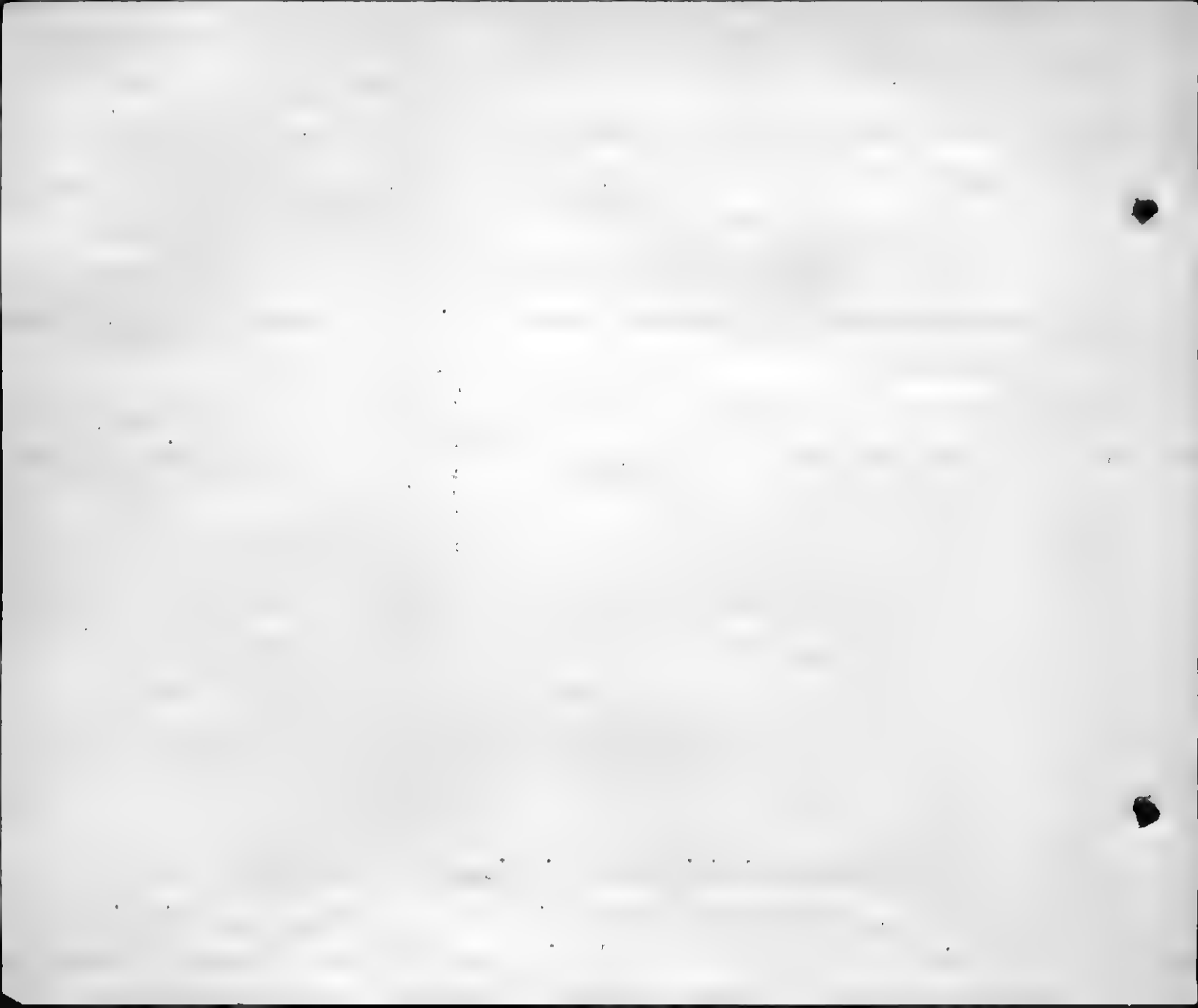
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | a. LENGTH OF STAY IN DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 5801 M. Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James Elbert Wood | | 4. DATE OF DEATH 12 12 1965 | | 5. SEX Male | |
| 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 13 Oct. 1965 | |
| 9. AGE (In years last birthday) yrs. 2 | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Pro Geo County, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Gerald Wood | | 14. MOTHER'S MAIDEN NAME Geraldine Dillman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Address Gerald Wood Hillside Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12-13-65 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 15, 1965 | | 22c. NAME OF CEMETERY OR Mt Oak Cemetery | |
| 22d. LOCATION (City, town, or county) Mitchellsville, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 17 1965 | | | |
| 23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 24b. REGISTRAR'S SIGNATURE Charles J. | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16926

CERTIFICATE OF DEATH

20308

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9524 49th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Theresa A. Yates | | 4. DATE OF DEATH Month December Day 1 Year 1965 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 6, 1917 |
| 9. AGE (In years last birthday) 48 yrs. | | IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Prince George, Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Edgar M. Talbott | | 14. MOTHER'S MAIDEN NAME Agnes M. Phelps | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 7205 B. Rossburg Dr. College Park, Maryland | |
| 17. INFORMANT Rose M. Suit | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral marked pulmonary edema DUE TO (b) Cardiomegaly DUE TO (c) edema CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 26, 1965 , to Dec 1, 1965 , that (I) (we) last saw the deceased alive on Nov 1, 1965 , and that death occurred at 2:55 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Don B. Cameron | | 22b. DATE SIGNED 12-1-65 | |
| 22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D. | | 22d. ADDRESS 3503 Perry St. Mt. Rainier, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/4/65 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | 23d. LOCATION (City, town or county) (State) Washington D. C. |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 6 1965 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB | | c. LENGTH OF STAY IN 1b 62 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON 83X 3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL | | | | d. STREET ADDRESS 1421 21ST STREET SOUTH | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last IDA Lee LOUISE YORK | | | | 4. DATE OF DEATH Month Day Year DECEMBER 15 1965 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUC | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2 APRIL 1886 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) PIKE COUNTY KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM A HARRIS | | | | 14. MOTHER'S MAIDEN NAME SARAH ANN TAYLOR | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HUSBAND | | Address SAME AS ITEM #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Death</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Sarcoma left pelvis wall, & metastasis</i> (c) <i>Generalized adenocarcinoma of the</i> cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 13 Oct 1965 to 15 Dec 1965 that (I) (we) last saw the deceased alive on 15 Dec 1965, and that death occurred at 0515 from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>William F Peterson</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM F PETERSON, COL, USAF, MC | | | | 22d. ADDRESS USAF HOSP ANDREWS AFB, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/17/65 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 23d. LOCATION (City, town or county) (State) Arlington Co. Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Everly Wheatley Funeral Home | | | | 25a. REC'D BY REGISTRAR DEC 20 1965 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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